

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 100 MILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19052

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE Joseph		LAST Allen		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR Jul 26 19 80		7b. HOUR 8:33 A M	
3. SEX male		4. RACE cauc.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1916		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR July 26 19 80		8. HOUR 8:33 Am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chiropractor		12b. KIND OF BUSINESS OR INDUSTRY Chiropractor							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 407 Meadowbrook Road					
14. FATHER'S NAME FIRST MIDDLE LAST John J. Allen, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian F. Flack											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Korean		478-12-9491		17. INFORMANT ADDRESS Mrs. Colleen M. Thomas, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) acute pulmonary edema 514		DUE TO, OR AS A CONSEQUENCE OF (b) advanced coronary atherosclerosis 410		DUE TO, OR AS A CONSEQUENCE OF (c) old septal myocardial infarction 414		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Harold R. Tritch, Jr.		TITLE (SPECIFY) deputy		M.D. MEDICAL EXAMINER		DATE SIGNED July 26, 1980					
EXAMINER'S NAME (TYPE OR PRINT) Harold Tritch, Jr.		ADDRESS 138 E. Antietam St. Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 29, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.							
24. FUNERAL DIRECTOR NAME MINNIGH FUNERAL HOME		415 E. Wilson Blvd. Hagerstown, Maryland 21740		25a. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]							

1952

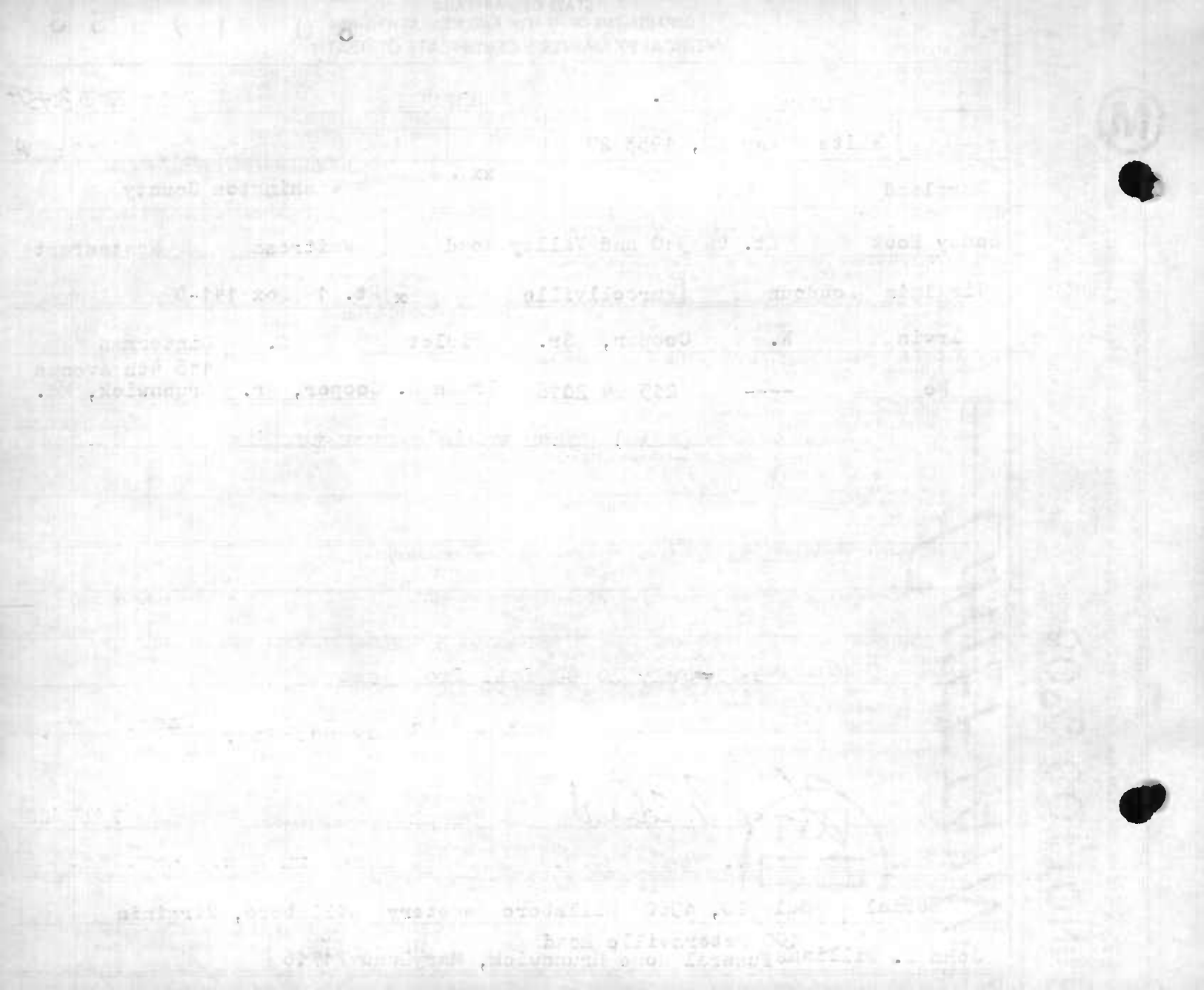
AUG 1 1952

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND										8019053					
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Sharon			E.		ASHBAUGH				July 17, 1980		3:45A				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2e. DATE PRONOUNCED DEAD		2f. HOUR	
Female		White		May 22, 1953		27						July 17, 1980		3:45A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			USA						Washington County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Sandy Hook			Rt. US 340 and Valley Road						Waitress			Restaurant			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS			
Virginia Loudoun			Purcellville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1 Box 141-D						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Irvin N. Cooper, Sr.			Violet E. Dinterman												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			215 64 2016			Irvin N. Cooper, Sr.			118 4th Avenue Brunswick, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (E816) Motor vehicle over turning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
3:45 July 17, 1980			fell from jeep												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
Street			Rt 340 & Valley Rd. Hag.			Wash. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			TITLE (SPECIFY) Deputy MEDICAL EXAMINER						DATE SIGNED 7/17/80						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS												
Howard N. Weeks, M.D.			580 Northern Ave., Hag. Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial			July 20, 1980		Hillsboro Cemetery			Hillsboro, Virginia							
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE						
John T. Williams			100 Petersville Road Funeral Home Brunswick, Maryland 21916						July 22 1980						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	9	0	5	4
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Homer Lampton ATWOOD										2a. DATE OF DEATH MONTH DAY YEAR July 26, 1980				2b. HOUR AM		
3 SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1890			6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS			7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD							
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 920 Mulberry Avenue				
14 FATHER'S NAME FIRST MIDDLE LAST Joseph David Atwood					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily C. Beam											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-6888-A			17 INFORMANT ADDRESS Mrs. Edna E. Atwood, Hagerstown, Md										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1889 DUE TO, OR AS A CONSEQUENCE OF (b) Transitional Cell Carcinoma of Bladder DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease - Diabetes Mellitus																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 90 Oct 19 65 to 26 July 19 80, that (I) (we) last saw the deceased alive on 25 July 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE W. H. Fender MD										DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-28-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. H. Fender					22e. ADDRESS 138 E. Antietam St. Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 29, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland								
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740										25a. DATE REC'D BY REGISTRAR JUL 31 1980		25b. REGISTRAR'S SIGNATURE D. J. Brady				

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 5 5	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST				MONTH DAY YEAR				HOUR MIN			
VICTORIA MYRTLE BABINGTON				July 23 1980				12:00 noon			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR			
female		white		MONTH DAY YEAR		61 YRS		MONTHS DAYS HOURS MIN			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital				Waitress					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
13a. Maryland				13b. Washington		13c. Hagerstown		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George W. Jones				Iva Myrtle Black							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No				212-14-7277		Mrs. Thelma Lum 319 Wakefield Rd. Hag.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Abdominal carcinomatosis								2 months			
1830 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the left ovary								unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
July 7 1980		Carcinoma of the left ovary				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19		none							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 23 1980, 19____, to July 23 1980, that (I) (we) last saw the deceased alive on July 23 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Francisco G. Japzon M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				Jul 25 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Francisco G. Japzon M.D.				645 E. First St Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		7/26/80		Salem United Methodist		Wolfsville Frederick Md.					
24 FUNERAL DIRECTOR				25a. DATE REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Little Funeral Home				JUL 30 1980		[Signature]					
504 Main Myersville, Md.											

Little General Store 501 Main Street, N.E. 401 30 1980

United Methodist Church, N.E. 401 30 1980

Francis G. Taylor, Jr.  
442 E. First St.  
Lawrence, MO. 64501

July 22 1980  
X  
July 22 1980

None

July 2 1980

Admission of the left eye

Abdominal carcinoma

2 at the

No

212-11-7277

Mrs. Thelma Lee

319

Wheeler Rd. N.E.

George

M.

Jones

Iva

Kyle

Black

Levyland Washington

Levyland Washington

X

11 W. Madison St.

Washington

Washington County Hospital

Address

Levyland

UD

Washington

Female

White

UNITED METHODIST CHURCH

July 22 1980

10:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 1 9 0 5 6	
FOR 1 - STATE REGISTRAR					CERTIFICATE OF DEATH	
REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Leon Robert BACHTELL			2a DATE OF DEATH MONTH DAY YEAR July 25, 1980		2b HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 20, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.
10 CITY OR TOWN OF DEATH Smithsburg		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 66 S. Main St.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b KIND OF BUSINESS OR INDUSTRY Cement Co.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Wash.		13c CITY OR TOWN Smithsburg	
14 FATHER'S NAME FIRST MIDDLE LAST Reuben H. Bachtell			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Longnecker			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-10-6845		17 INFORMANT ADDRESS Mrs. Mazie M. Bachtell, Smithsburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Prostate</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>7-30</u> 19 <u>57</u> to <u>7-25</u> 19 <u>80</u> , that (we) last saw the deceased alive on <u>7-22</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did/did not view the body after death.)						
22b SIGNATURE <u>Charles F. Hess</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7-25-80
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.		22e ADDRESS Smithsburg, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE July 29, 1980		23c NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.
24 FUNERAL DIRECTOR NAME <u>Lewis J. Davis</u>		ADDRESS Davis Funeral Home, Smithsburg, Md.		25a DATE REC'D. BY REGISTRAR JUL 30 1980		
				25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



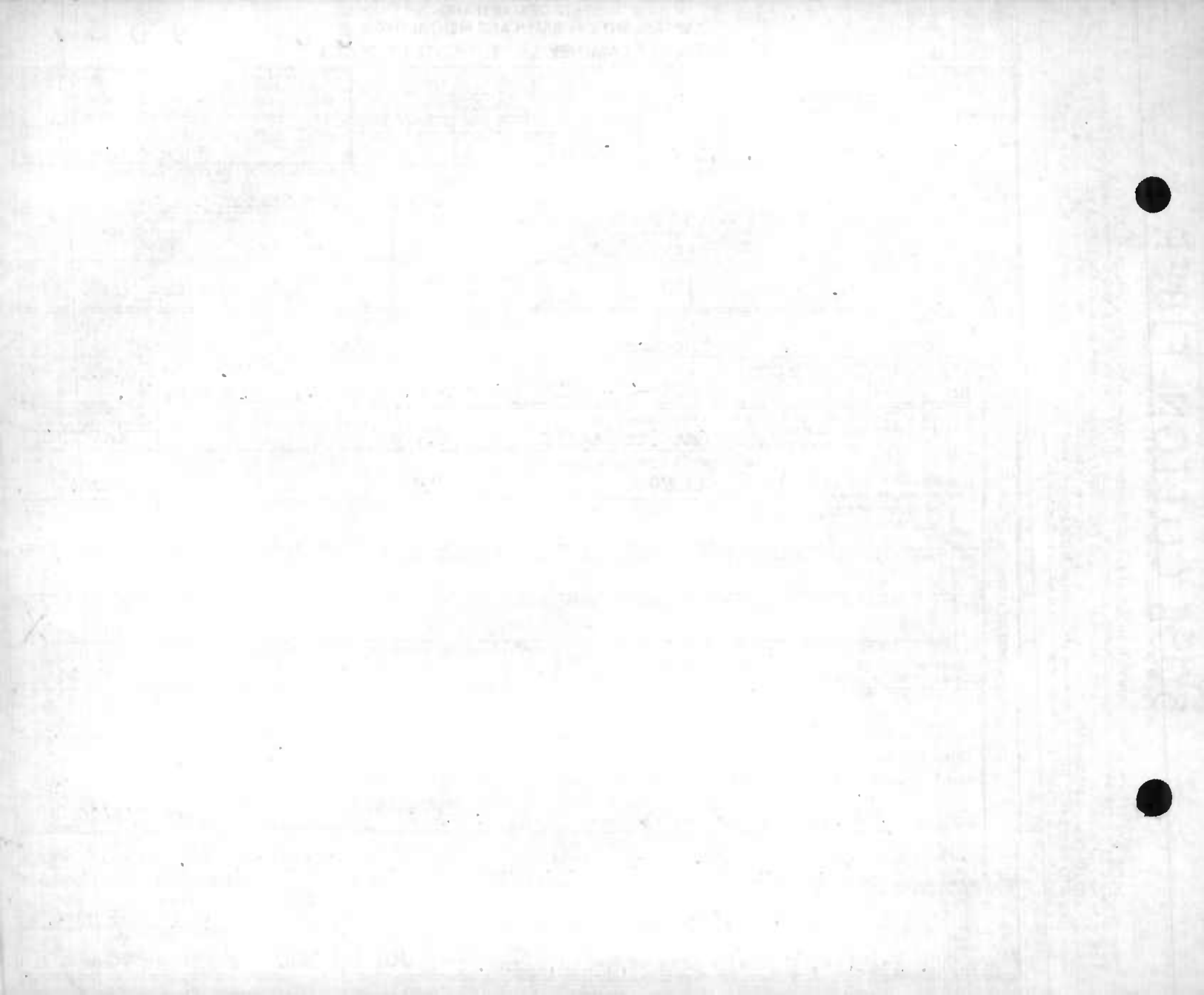


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19057	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FLOSSIE P. BAER</b>							2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>July 6 1980</b>		2a. HOUR <b>7:00 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14, 1889</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>90 YRS.</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>July 6 1980</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>274 Potomac Heights</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>274 Potomac Heights</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard M. Proctor</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Whinnery</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-03-0422</b>		17. INFORMANT <b>Martha L. Creager, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>427</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>ASCVD</b> <b>429</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Harold R. Tritch, Jr.</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7/7/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R. Tritch, Jr., M.D.</b>				ADDRESS <b>138 E. Antietam St., Hagerstown, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 9, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Delta York Penna.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Harkins, 600 Main Street, Delta, Penna.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Harry A. Brady</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 0 5 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Franklin Baker			2a. DATE OF DEATH July 29, 1980		2b. HOUR 10:20 PM
3 SEX male	4 RACE white	5 DATE OF BIRTH Feb. 1, 1905	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24 Wynnwood Dr.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) milk & general haul		12b KIND OF BUSINESS OR INDUSTRY Clines Mill
13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Williamsport	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS Rt. 3
14 FATHER'S NAME FIRST MIDDLE LAST Keiffer Baker		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jennie Smith			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-3724		17 INFORMANT ADDRESS Mrs. Nancy Moser Rt. 3 Box 195 Wmspt., MD	
18 CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Complication of pancreas in metastasis</i> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Many body parts</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 5-29-80 to 7-29-80, that (I) (we) lost saw the deceased alive on 7-20-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>E. R. Landis</i>		DEGREE		22c. DATE SIGNED 7-21-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) E. R. Landis		22e ADDRESS 382 John D. Leppard, Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 1, 1980		23c NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park	
23d LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD					
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD		25a DATE REC'D. BY REGISTRAR AUG 5 1980		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Wm 2244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR <b>Floyd Sheddan Bennett Jr.</b> <b>CERTIFICATE OF DEATH</b>									
REG. NO. <b>8 0 1 9 0 5 9</b>									
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. HOUR			
<b>FLOYD SHEDDAN BENNETT JR.</b>			<b>JULY 13 1980</b>			<b>3:30 P.M.</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
<b>Male</b>		<b>White</b>		<b>AUG 9, 1916</b>		<b>63</b> YRS.		<b>MONTHS DAYS HOURS MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<b>North Carolina</b>		<b>U.S.A.</b>				<b>Washington County MD</b>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>Hagerstown</b>		<b>Washington County Hospital</b>				<b>Vice President</b>		<b>Aircraft</b>	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
<b>Maryland</b>			<b>Washington</b>		<b>Hagerstown</b>		<b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. STREET ADDRESS			
<b>FLOYD S. BENNETT</b>			<b>MAYE BOWLING</b>			<b>1666 Fountain Head Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		
<b>No</b>			<b>217-12-2482</b>		<b>Doris S. Bennett</b>		<b>1666 Fountain Head Road Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sezary Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						<b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		<b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (1) (this hospital) attended the deceased from <b>June 30, 1980</b> to <b>July 13, 1980</b> , that (1) (we) last saw the deceased alive on <b>July 12, 1980</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (and not) view the body after death.									
22a. SIGNATURE			22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
<b>Robert Brull</b>			<b>MD</b>					<b>7/14/80</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS						
<b>Robert Brull</b>			<b>1198 Kenly Ave. Hagerstown</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
<b>Burial</b>			<b>7-15-80</b>		<b>Rest Haven Cemetery</b>		<b>Hagerstown, Washington, Md.</b>		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25. DATE RECD. BY REG. NO. 25b. REG. NO. OF SIGNATURE			
<b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>						<b>JUL 21 1980</b>			

BP.

Board members list of 1911

July 12 1911  
Barnett 26  
Hale

North Carolina

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff

Washington County Sheriff





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FRED R. BOWARD		July 12, 1980		7:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	Oct. 8, 1905	74	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Penna.	U.S.A.		Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Leitersburg	Hagerstown R. D. 5	Painter	contracting		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Washington	Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Box 288 R. D. 5	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George W. Boward		Mary Ellen Cunningham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		160-16-7557	Box 288 R. D. 5 Hagerstown, Md.		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma of</u> <u>1419</u> <u>tongue</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
				7/13 75 to 7/12 80	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>75</u> to <u>7/12</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7/22</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27a. SIGNATURE		DEGREE		27c. DATE SIGNED	
<u>Donald E Martin MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>7/14/80</u>	
27b. PHYSICIAN'S NAME (TYPE OR PRINT)		27d. ADDRESS			
DONALD E MARTIN		363 S Cleveland Ave Hagg, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7/15/1980	Green Hill	Waynesboro Franklin Penna.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
<u>David Y. Gatz</u>		Waynesboro, Penna.		JUL 22 1980	

MEDICAL CERTIFICATION

Washington, D.C.  
Box 208  
Rt. 1  
Hagerstown, Md.

Ellen

Harry

David

W.

George

no

100-10-77-7 Mr. H. Louise Lewis

Washington, D.C.  
Box 208  
Rt. 1  
Hagerstown, Md.

Box 208 X

Washington Hagerstown

Hagerstown, D.C.

Rt. 1

Construction

Washington

James

W. A.

X

Nov. 8, 1977

W

Washington

W

Male

1977

W

David

July 15, 1970

1:50 p

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR	
Curtis Henry Bowlus			7/4/80		12:15 PM						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Caucasian		Dec. 13, 1928		51 YRS		MONTHS		DAYS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Washington Co.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington Co. Hospital		Welder		U.S. Gov't.					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. COUNTY		19. CITY OR TOWN		20. INSIDE CITY LIMITS?		21. STREET ADDRESS	
Md.		Fred.		Middletown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8050 Bolivar Rd.			
22. FATHER'S NAME		23. MOTHER'S MAIDEN NAME		24. INFORMANT		25. ADDRESS					
RALPH H. BOWLUS		NELLIE M. LAPOLE		Betty Bowlus		Middletown, Md.		21769			
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		27. SOCIAL SECURITY NO.		28. DATE OF DEATH		29. DATE OF BIRTH		30. DATE OF DEATH		31. DATE OF BIRTH	
Yes		H951-1953		218-24-7699		218-24-7699		218-24-7699		218-24-7699	
32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
33. DATE OF OPERATION		34. CONDITION FOR WHICH OPERATION WAS PERFORMED		35. AUTOPSY?		36. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (1) (this hospital) attended the deceased from <u>6-30-</u> 19 <u>80</u> , to <u>7-4-</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>7-3-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		23. SIGNATURE <u>Jose P. Secordari</u>		24. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		25. DATE SIGNED 7-4-80					
26. PHYSICIAN'S NAME (TYPE OR PRINT)		27. ADDRESS		28. BURIAL, CREMATION, REMOVAL (SPECIFY)		29. DATE		30. NAME OF CEMETERY OR CREMATORY		31. LOCATION CITY OR TOWN COUNTY STATE	
JOSEPH SECORDARI		BOONSBORO 21713		Burial		July 7, 1980		Lutheran Cem.		Middletown Fred. Md.	
32. FUNERAL DIRECTOR NAME		33. ADDRESS		34. DATE REC'D. BY REGISTRAR		35. REGISTRAR'S SIGNATURE					
Gladhill Co. Middletown, Md.		21769		JUL 9 1980		<u>R. J. H. H. H.</u>					

General on Dec. 13, 1950

Washington, D.C.

Dear Sir:

I am writing to you

to inform you

that

the following

information

is being

provided to you

for your

reference.

Very truly yours,

John F. Kennedy

President

Enclosure

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JUL 1980

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19062			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CAROL LYNN CAPINO</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>JUL. 22 19 80</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 2, 1958</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>21</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>JULY 22 19 80</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.			12b. KIND OF BUSINESS OR INDUSTRY <b>Motor Inn</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maid</b>							
13a. STATE COUNTY CITY OR TOWN <b>Maryland Frederick Frederick</b>										13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>130 E. 5th Street, Frederick, Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17. INFORMANT ADDRESS <b>Roy B. Capino, 130 E. 5th Street, Frederick Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>8183</b> IMMEDIATE CAUSE (a) <b>E818 - FALL FROM MOVING VEHICLE (MOTORCYCLE)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(CEREBRAL CONCUSSION WITH MASSIVE CEREBRAL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EDEMA)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <b>4:50 P.M. JUL. 18 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>PASSENGER ON MOTORCYCLE; FELL FROM VEHICLE WHEN REAR TIRE BLEW OUT</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>IS 70</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>FRONT SHERATON MOTOR INN, FREDERICK, FRED., MD.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Edward W. Ditto</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>JULY 23, 1980</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jul 25, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert C. Sanford, 106 East Church St., Frederick, Md. 21701</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL - 8 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1910

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JULY 1, 1909

ALBANY:  
J.B. LEECH, PRINTERS  
1910

THE LAND OFFICE  
OF THE STATE OF NEW YORK  
ALBANY

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/1/00 BY SP-6/ML

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8019063		
1. FOR STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Cecile Frances CAREY					2a. DATE OF DEATH MONTH DAY YEAR 7 12 1980			2b. HOUR 9:50 A M				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR November 1, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr. & Ex. Sec.			12b. KIND OF BUSINESS OR INDUSTRY country club			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 106 Park Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas McLaughlin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Lynch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 199-07-0361		17. INFORMANT ADDRESS Mrs. Mabel O'Neill, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterioscl. Heart Disease with</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Chronic Vascular Obstructive Disease</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>77</u> , to <u>July 12</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Jan 12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>B. B. Kneisel MD</u>					DEGREE		22c. DATE SIGNED 7/14/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. B. Kneisel</u>					22e. ADDRESS <u>148 W. Washington St. Hagerstown Md.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE July 15, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE <u>B. B. Kneisel</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 6 4		
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.		
1 DECEASED NAME (TYPE OR PRINT) Lenora Virginia COALE					2a. DATE OF DEATH MONTH DAY YEAR July 2, 1980					2b. HOUR 9:00 A.M.		
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR February 19, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 746 Summit Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST unknown					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Joseph E. Coale, Sr., Hagerstown, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410 - DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Advanced Arteriosclerotic Coronary Arterial Disease 10 years</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive Heart Failure; Atrial Fibrillation</u>												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>Feb 19 79</u> to <u>July 2 80</u> , that (I) (we) lost saw the deceased alive on <u>May 23 80</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) not view the body after death.												
22b SIGNATURE <u>Robert R. Brubaker</u>		22c DEGREE <u>MD</u>		22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e DATE SIGNED <u>7/2/80</u>				
22f PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Brubaker</u>		22g ADDRESS <u>1198 Karly Ave Hagerstown</u>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE July 5, 1980		23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d LOCATION CITY OR TOWN STATE Hagerstown, Wash., Maryland				
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		24b ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a DATE RECD. BY REGISTRAR JUL 7 1980				25b SIGNATURE <u>[Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified for advice.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		8 0 1 9 0 6 5				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John David COFFMAN						2a. DATE OF DEATH MONTH DAY YEAR July 26, 1980		2b. HOUR 6:05 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 26, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) St. James, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney- Keedy Memorial Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Coffman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Reichard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-7039		17. INFORMANT Mrs. Mary A. Crampton,		ADDRESS 8 Young Ave. Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Insufficiency</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 4380 HACKS (24)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>65</u> to <u>7/26</u> 19 <u>80</u> , that (I) <del>met</del> <u>lost</u> saw the deceased alive on <u>7/25</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. D. Wilson, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/28/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M. D.				22e. ADDRESS 580 Northern Ave., Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-29-80		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION CITY OR TOWN COUNTY Tilghmanton, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19066		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY MARGARET COLDREN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR JUL. 20 19 80		2b. HOUR OF ESTI- MATED DEATH 2:45 P.M.
3. SEX FEMALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1896	6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR JULY 20 19 80		2d. HOUR 4:15 P.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Washington Co Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY Homemaker				
13a. STATE Penna.		13b. COUNTY Franklin	13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. # 4						
14. FATHER'S NAME FIRST MIDDLE LAST Charles Coldren			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gennie E. Donahue									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 198-18-1657-D		17. INFORMANT ADDRESS George E. Dopp, Greencastle, Pa.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #486 - PNEUMONIA - #038 - SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) #E885 - FALL ON SAME LEVEL (BATHTUB) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH APPROX. 5 DAYS 27 DAYS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION 6/25/80 7/4/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RICHARDS NAILING - LEFT HIP LT. CRANIOTOMY & RT. BURRHOLE (BILATERAL SUBTOTAL)						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30 AM JUNE 23 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. OR PART 2) FELL WHILE IN BATHTUB								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 342 YOUNG DRIVE, GREENCASTLE, FRANKLIN, PENNA.								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Edward W. Ditto		TITLE (SPECIFY) M.D. DEPUTY		MEDICAL EXAMINER 217 WEST WASHINGTON STREET				DATE SIGNED JULY 21, 1980				
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		ADDRESS HAGERSTOWN, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/1980		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fayette Co. Penna.						
24. FUNERAL DIRECTOR NAME Harold H. Zimmerman		ADDRESS Greencastle Pa		25a. DATE REC'D. BY REGISTRAR JUL 25 1980		25b. REGISTRAR'S SIGNATURE [Signature]						

SECRET

SECRET

(ATTENTION: JAMES EARL RAY)

RE: JAMES EARL RAY - FUGITIVE  
FUGITIVE - JAMES EARL RAY - FUGITIVE

ALL INFORMATION IS UNCLASSIFIED

ALL INFORMATION IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 6 7		
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Mary Jane CRAIG						July 7, 1980					8:10 A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female			white			July 13, 1917			62		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA						Washington MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Washington County Hospital			housewife						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS			
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 120 E. Antietam St.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST			FIRST MIDDLE LAST									
Harry William Suter			Grace Rummel									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			214-09-4391			Melvin L. Craig, Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 4140 Arteriosclerotic Heart Disease										2 1/2 years		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):												
Pulmonary emphysema. Petit Mal												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE									
21f. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												
22a. I certify that (1) (this hospital) attended the deceased from June 27, 19 80, to July 7, 19 80, that (1) (X) (we) lost saw the deceased alive on June 27, 19 80, and that in (my) (X) (X) opinion death occurred on the date and hour and from the causes stated above, (1) (X) (we) did not view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
W. T. Layman, M.D.									7/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
W. T. Layman, M.D.			301 E. Antietam St., Hagerstown, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
burial			July 10, 1980			Rose Hill Cemetery			Hagerstown, Washington, Md.			
24. FUNERAL DIRECTOR			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
MINNICH FUNERAL HOME			415 E. Wilson Blvd., Hagerstown, Md. 21740			JUL 11 1980			[Signature]			

MEDICAL CERTIFICATION

1000

U. S. GOVERNMENT PRINTING OFFICE  
1910

*Handwritten signature*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73  
(V R A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
GEORGEANNA NMN CRAWFORD			July 7 80					11:45P <sub>M</sub>					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		white		6 MONTH 24 DAY 10 YEAR		70 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Washington County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		11 West Baltimore Street		Laundry		Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11 West Baltimore Street					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
George Schaffer Jones		Mary Margarita Davis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		213-24-8589		Wanda M. Rohrer		155 Summit Avenue							
						Hagerstown, Md. 21740							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										instant			
IMMEDIATE CAUSE (a) Acute myocardial infarction													
410 - DUE TO, OR AS A CONSEQUENCE OF										YEARS			
(b) ASCVD													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from May 1, 19 62, to July 7, 19 80, that (I) last saw the deceased alive on July 7, 19 80, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Harold R. Tritch, Jr.		MD		7/8/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Harold R. Tritch, Jr., M.D.		138 E. Antietam St., Hagerstown, MD 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		7-10-80		Rest Haven Cemetery		Hagerstown, Washington, Md.							
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
A.K. Coffman Funeral Home, Inc., Hagerstown, Md.													

BP

Washington County

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY	YEAR	2b. HOUR A M
DONALD RICHARD Dailey DALEY					X July 30 19 80						3:30
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Dec. 7, 1922		57 YRS.	MONTHS		DAYS		July 30 19 80		10:00
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Hagerstown, Md.		U. S. A.			WIDOWED		DIVORCED		Washington		MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		36 N. Potomac St.				Jeweler		Jewelry			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Washington		Hagerstown		YES X NO		216 Potomac Hgts.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Strother Dailey				FIRST MIDDLE LAST Edna Munday							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes				W. W. Two		219- 14- 7851		Mrs. Helen N. Dailey		216 Potomac Hgts. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to head E-955</u> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Harold R. Tritch, Jr.</u>				TITLE (SPECIFY) M.D. <u>deputy</u>				MEDICAL EXAMINER		DATE SIGNED <u>7/30/80</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Harold R. Tritch, Jr., M.D.</u>				ADDRESS <u>138 E. Antietam St., Hagerstown, MD</u>							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		8-1-80		Rose Hill Cemetery				Hagerstown Wash. Co. Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
John H. Bast, Jr.				Boonsboro, Md. 21713				AUG 1 1980			

CONFIDENTIAL

DATE: 10/1/55

REPORTED BY: [illegible]

BY: [illegible]

REASON: [illegible]

REMARKS: [illegible]

DATE: 10/1/55

REPORTED BY: [illegible]

BY: [illegible]

REASON: [illegible]

REMARKS: [illegible]

DATE: 10/1/55

REPORTED BY: [illegible]

BY: [illegible]

REASON: [illegible]

REMARKS: [illegible]

DATE: 10/1/55

REPORTED BY: [illegible]

BY: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 9 0 7 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDNA LAVINA DAVIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7 13 80</b>		2b. HOUR <b>5 35 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 4 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash Co Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper---</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Schell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie "HN KNOWN"</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>214--62-3924</b>		17. INFORMANT <b>John A. Davis</b>		ADDRESS <b>53 Cresap Street Cumberland, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Interosseal ventricular aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>7/11/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Legumens left foot</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8 July 19 80</b> to <b>13 July 19 80</b> , that (I) (we) last saw the deceased alive on <b>12 July 19 80</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>John R. Marshall</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>13 July 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Marshall</b>		22e. ADDRESS <b>239 N. POTOMAC ST. HAGERSTOWN, MD 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 16/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Herman Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Silcox-Merritt</b>				ADDRESS <b>Funeral Service, Cumberland, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1980</b>	
				25b. REGISTRAR'S SIGNATURE			

BP

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 0 1 9 0 7 1					
1 DECEASED NAME (TYPE OR PRINT) <b>Mary Elizabeth DAVIS</b>					2a DATE OF DEATH MONTH DAY YEAR <b>July 15, 1980</b>			2b HOUR <b>M</b>		
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 25, 1887</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>230 E. Potomac St.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John NNN Baker</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth NNN Poffenberger</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <b>Mrs. Margaret Reid item # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Ischemic Heart Disease</b> (c) <b>Ischemic Heart Disease</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>Dec. 12, 1976</b> to <b>July 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John R. Melnick</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick, M.D.</b>					22e. ADDRESS <b>16220 Frederick Rd. Gaithersburg, MD 20760</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/21/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington MD</b>			
24 FUNERAL DIRECTOR NAME <b>Osborne Funeral Home P.O. Box 348 Wmspt., MD</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 7 2	
FOR 1- STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet Mae Davis				2a. DATE OF DEATH MONTH DAY YEAR July 21, 1980				2b. HOUR AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 8, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 226	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Hornbaker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Honrietta Kerns							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-2114		17 INFORMANT ADDRESS Frances Cunningham Rt. 1 Box 239A Wmspt., MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>renal vascular accident; Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>80</u> , to <u>July 21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edmund Mundy MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/23/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/24/80		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Tilghmanton Washington MD			
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD						25a. DATE REC'D. BY REGISTRAR JUL 28 1980		25b. REGISTRAR'S SIGNATURE <u>Edmund Mundy</u>			

JUL 2 1968

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19073	
1. DECEASED NAME (TYPE OR PRINT) <b>KIM Lien DIVEBLISS</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>July 26 1980</b>	
3. SEX <b>Female</b>		4. RACE <b>Asian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-28-49</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>31</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>July 26 1980</b>		2b. HOUR <b>3:00</b> A M P M <b>A M</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Viet Nam</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hancock</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. #2</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Co.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Darlington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4004 Paddrick Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215 76 7132</b>		17. INFORMANT ADDRESS <b>Stanley R. Divelbliss same as deceased</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9505</b> IMMEDIATE CAUSE (a) <b>Drug Overdose</b> <b>E-950</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Harold R. Tritch, Jr.</b>						TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>7/28/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R. Tritch, Jr., M.D.</b> ADDRESS <b>138 E. Antietam St., Hagerstown, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-29-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Richard J. Grove Hancock MD</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG. 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Susan Jane Dues</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7/21/1980</i>		2b. HOUR <i>4:10 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 22 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Johnstown, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Boonsboro</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fahney-Keedy Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>Ashtabula</i>		13c. CITY OR TOWN <i>Ashtabula</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Armstrong</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Oppy Armstrong</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>274-46-7063</i>	
17. INFORMANT <i>Fahney Keedy Nurse</i>		18. ADDRESS <i>Boonsboro Md</i>		19. ADDRESS <i>Rt 2</i>		20. ADDRESS <i>Rt 2</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>5990</i> DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c):		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-5 days</i>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
*ASCD, Paget Disease*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 13</i> , 19 <i>78</i> , to <i>July 21</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>5.22</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Vasant Datta</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7.21.80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VASANT DATTA, MD</i>		22e. ADDRESS <i>1600 OAK HILL AVE, HALERS TOWN, MD 21740</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>July 23, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Edgewood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ashtabula Ohio</i>	
24. FUNERAL DIRECTOR NAME <i>Arvid Minnich</i>		ADDRESS <i>Greencastle, Pa. 17225</i>		25a. REG. BY <i>REC. BY 1000</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

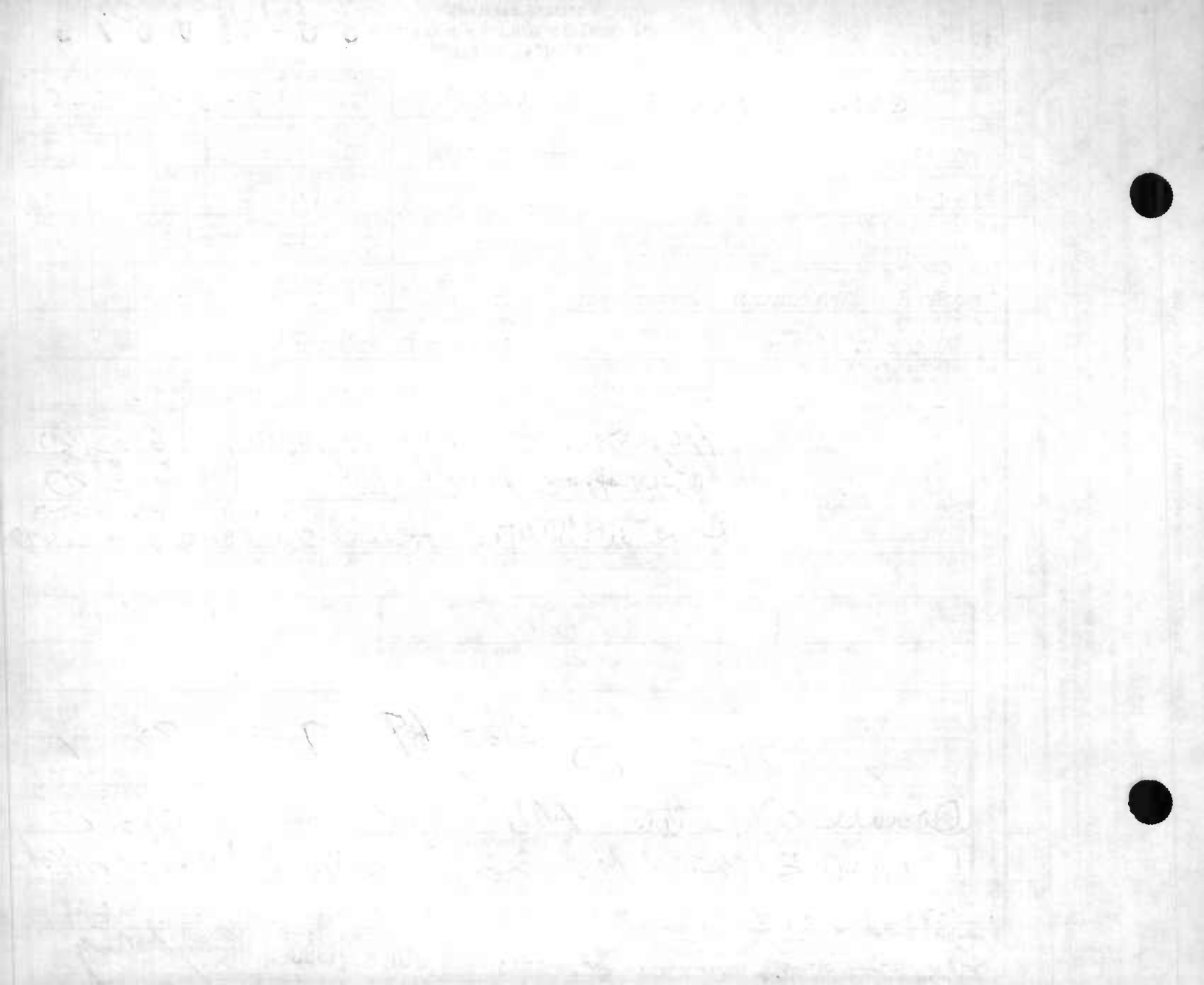
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 9 0 7 5  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ESSIE DRENE ECKARD.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>7-3-80</b>			2b HOUR <b>5:45</b> AM				
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 2, 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>0 0 0 0</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>9 W. Howard Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Walter T. Hinton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara E. Painter</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b SOCIAL SECURITY NO. <b>212-24-3750</b>		17 INFORMANT ADDRESS <b>Mrs. John Crawford, Hagerstown, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoxic Encephalopathy</b> <b>4/40</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6/22/80</b> <b>4/22/80</b> <b>PRIOR TO 6/22/80</b>								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>6/30/87 7/13/80</b>					
22a I certify that (I) (this hospital) attended the deceased from <b>7/2</b> 19 <b>80</b> to <b>7/3</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/2</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Donale E Martin</b>			DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>7/3/80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD E MARTIN M.D.</b>					22e ADDRESS <b>363 S Cleveland Ave Hager Md</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b DATE <b>July 7, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>					25a DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			
26 ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHAM - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 19076
1- FOR STATE REGISTRAR												
2- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANET PAULINE GARLAND												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> July 11 1980
3- SEX Female	4- RACE White	5- DATE OF BIRTH MONTH DAY YEAR 6 28 16	6- AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	7- IF UNDER 1 YR MONTHS DAYS	8- IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD July 11 1980	9- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		11- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		11- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10- CITY OR TOWN OF DEATH Hagerstown		11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H.S. Heinz Co.		12b. KIND OF BUSINESS OR INDUSTRY		13- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		14- BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
13a. STATE Pa.		13b. COUNTY Franklin		13c. CITY OR TOWN Chambersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 231 Irva Dr. E.		17201		
14- FATHER'S NAME FIRST MIDDLE LAST John A. Hamil		15- MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Myers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 159-24-8031		17- INFORMANT ADDRESS Clara S. Hendershot, McConnellsburg, Pa.		17233		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) tension pneumothorax & acute pulmonary failure												min
DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive pulmonary disease 496												496 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) developed tension pneumo during resuscitation								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> - Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Harold R. Tritch, Jr.		TITLE (SPECIFY) Asst.		MEDICAL EXAMINER		DATE SIGNED 7/11/80						
EXAMINER'S NAME (TYPE OR PRINT) Harold R. Tritch, Jr., M.D.		ADDRESS 138 E. Antietam St.		Hagerstown, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 14, 80		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION CITY OR TOWN COUNTY STATE		Cyr. Twp. Fulton Co. Pa.				
24. FUNERAL DIRECTOR NAME Roy C. Dawson		ADDRESS 1037 Dual Pl., Hagerstown, Md		25a. DATE REC'D BY REGISTRAR 502 6 6 1980		25b. REGISTRAR'S SIGNATURE						



CHARTERED BY THE BOARD OF DIRECTORS

CHARTERED BY THE BOARD OF DIRECTORS

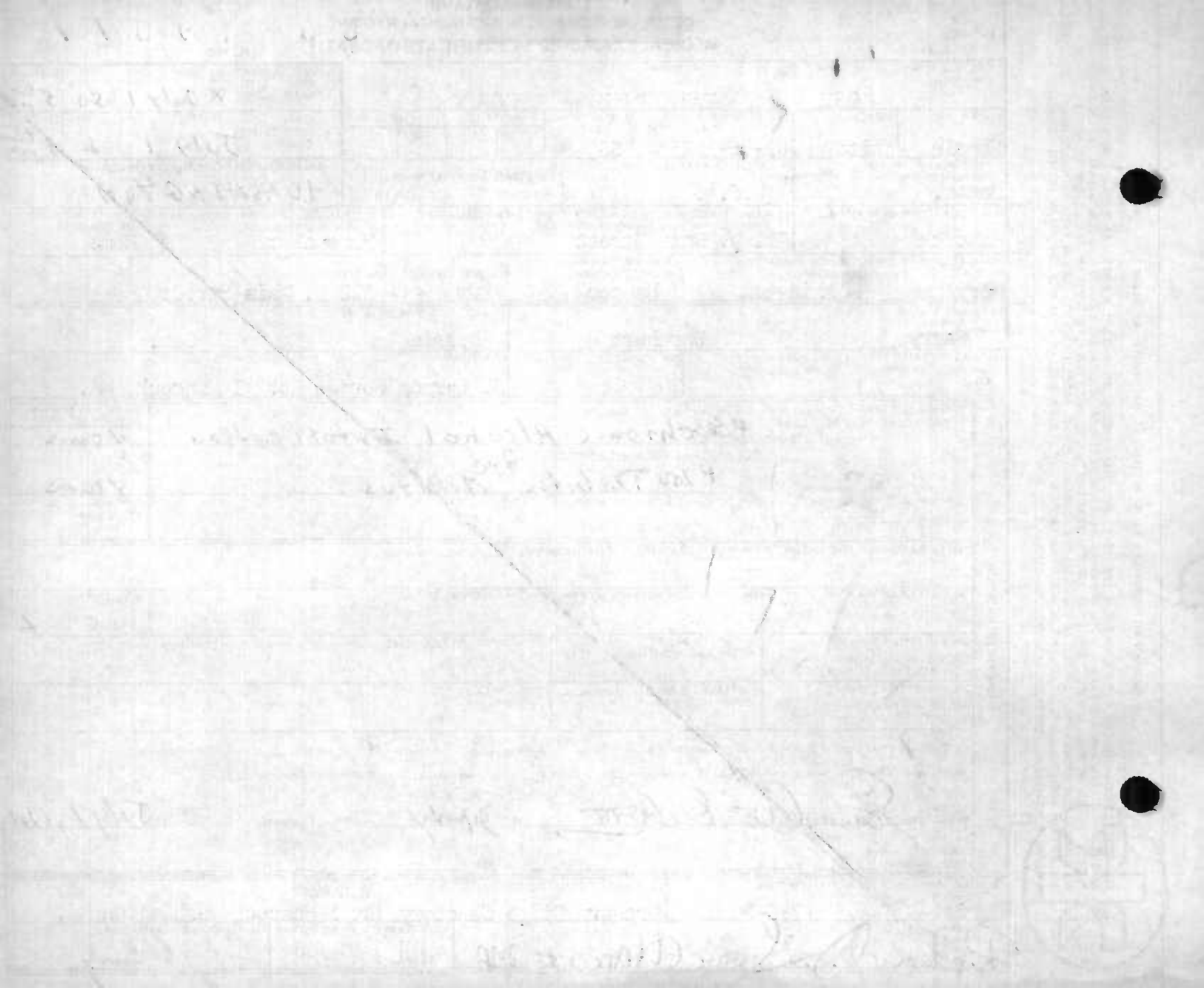
CHARTERED BY THE BOARD OF DIRECTORS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19077	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE KATHERINE GORDON										2b. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> July 1 1980	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02-06-1925		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD July 1 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH Hancock				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 122 W. Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 122 W. Main Street			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Barnhart						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Seal					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS J. Carmon Gordon Rt. #1 Hancock, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Alcohol Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF <u>2nd</u> (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) 303 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Richard W. Dittman</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER		DATE SIGNED July 1, 1980	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-5-80		23c. NAME OF CEMETERY OR CREMATORY Orchard Ridge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Rt 1 Hancock Washington Md.		
24. FUNERAL DIRECTOR NAME <u>Richard W. Dittman</u>				ADDRESS <u>Hancock MD</u>				25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>	

BP





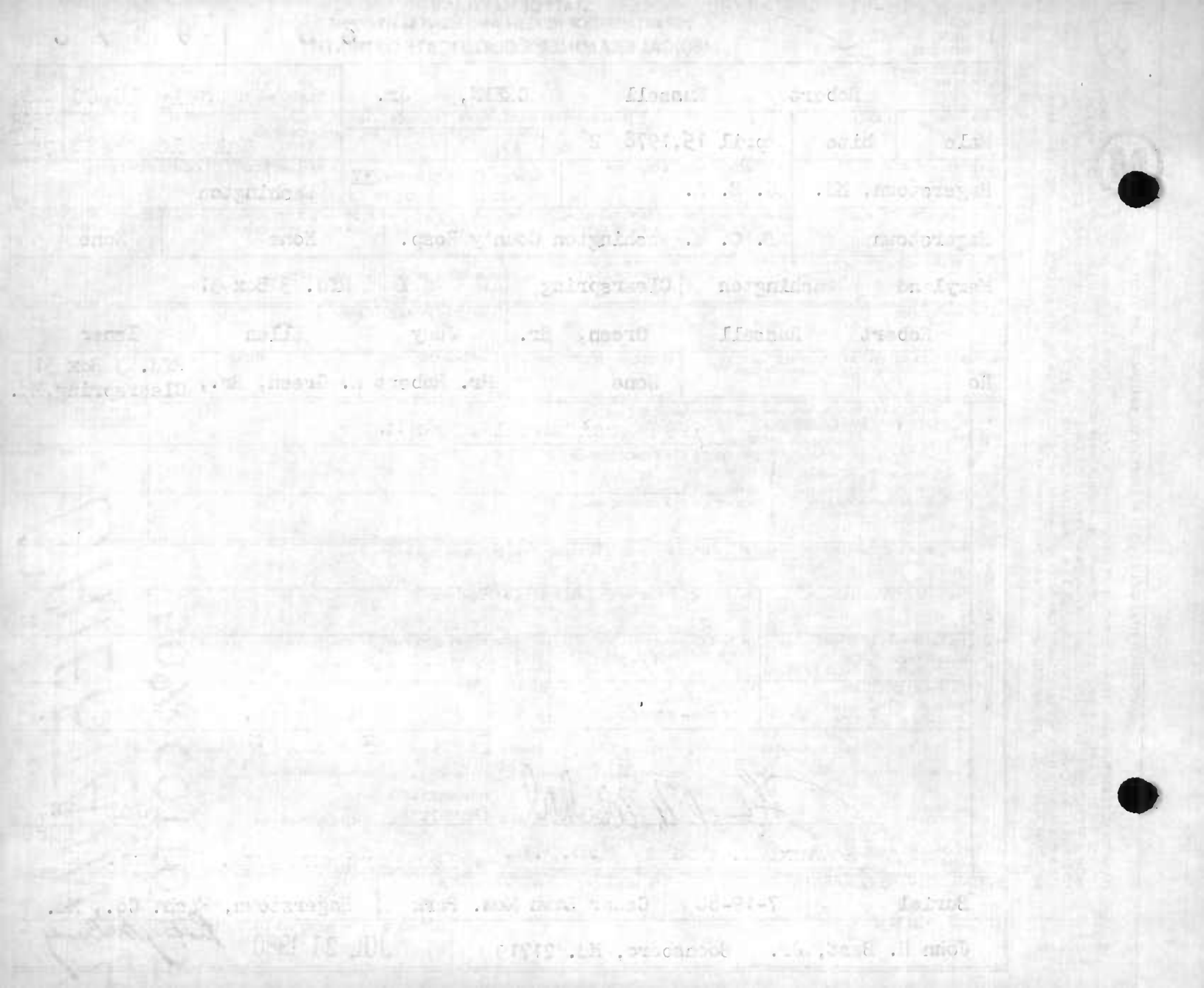


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19078	
1. DECEASED NAME (TYPE OR PRINT) <b>Robert Russell GREEN, Jr.</b>										2a. DATE KNOWN OF DEATH <b>July 16, 80</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 15, 1978</b>		6. AGE (IN YEARS) <b>2</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE ESTIMATED <b>July 16, 80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown, Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>D. O. A. Washington County Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Clearspring</b>		13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS <b>Rfd. 3 Box 31</b>			
14. FATHER'S NAME <b>Robert Russell Green, Sr.</b>						15. MOTHER'S MAIDEN NAME <b>Judy Ellen Isner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mr. Robert R. Green, Sr., Rfd. 3 Box 31 Clearspring, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>N994 Accidental Drowning</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>9/108</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>7/16/80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>fell into swimming pool</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home-yard</b>		21f. LOCATION <b>Clearspring, Washington, Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Howard N. Weeks</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>July 18, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Howard N. Weeks, M.D.P.A.</b>				ADDRESS <b>580 Northern Ave. Hagers. MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>7-19-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>			23d. LOCATION CITY OR TOWN <b>Hagerstown, Wash. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr.</b>						ADDRESS <b>Boonsboro, Md. 21713</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR <b>Anthony M. Brady</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND												
DEPARTMENT OF HEALTH AND MENTAL HYGIENE												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
REG. NO. 19079												
FOR 1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Charles Robert Guessford</u>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <u>July 31 1980</u>		7b. HOUR <u>4:30AM</u>				
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Sept 24 21 58</u>		6. AGE (IN YEARS) LAST BIRTHDAY <u>58</u> YRS.		IF UNDER 1 YR. MONTHS DAYS <u>m</u>		IF UNDER 24 HRS. HOURS MIN <u></u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County</u> MD.		
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>119 King Street</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Shop Foreman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>			13c. CITY OR TOWN <u>Hagerstown</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>119 King Street</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Carl William Guessford Sr.</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mabel Palmer</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>214-16-1824</u>		17. INFORMANT ADDRESS <u>Irene E. Chaney Route # 2 Box 14 Clear Spring, Md. 21722</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> 410 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Harold R. Tritch Jr</u>				TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER				DATE SIGNED <u>July 31, 1980</u>				
EXAMINER'S NAME (TYPE OR PRINT) <u>Harold R. Tritch, Jr., M.D.</u>				ADDRESS <u>138 E. Antietam St., Hagerstown, Md. 21740</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>8-4-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Washington, Md.</u>		
24. FUNERAL DIRECTOR NAME ADDRESS <u>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>AUG 6 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

0021-8758/94/0005-0000\$05.00/0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 8 0 1 9 0 8 0									
1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve Louise Hahn</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 6, 1980</b>		2b. HOUR <b>4:05 pm</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 27, 1921</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b>		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10 CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Reeders' Memorial Home, Inc.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>438 Mitchell Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Ruck</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie Shoop</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-12-1581</b>		17 INFORMANT <b>Leonard R. Hahn</b>		ADDRESS <b>438 Mitchell Avenue Hagerstown, Md.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepatic Coma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5722 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hepatic Encephalopathy</b>									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 27</b> 19 <b>80</b> to <b>July 6</b> 19 <b>80</b> , that I (we) lost saw the deceased alive on <b>7/2/80</b> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Milani M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-7-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MOKHTAR MILANINIA, M.D.</b>					22e. ADDRESS <b>11 Sheridan Dr., Williamsport, Md. 21795</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-9-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ros e Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>					25. DATE RECD. BY REG. CLERK 75b. REGISTRAR'S SIGNATURE <b>JUL 10 1980</b>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

1. FOR STATE REGISTRAR		7a. DATE OF DEATH		7b. HOUR	
DECEASED NAME (FIRST MIDDLE LAST) <b>NELSON THEODORE HANCOCK</b>		July 19, 1980		940 P M	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH (MONTH DAY YEAR) <b>May 1, 1914</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	8 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD</b>		
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17 McComas Street</b>	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Maryland</b> 13c COUNTY <b>Washington</b> 13d CITY OR TOWN <b>Hagerstown</b>		13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14 STREET ADDRESS <b>17 McComas Street</b>		
14 FATHER'S NAME (FIRST MIDDLE LAST) <b>Charles Edward Hancock</b>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Lucy Ann Faulders</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO <b>214-09-1069</b>	17 INFORMANT ADDRESS <b>Beatrice Hancock, 17 McComas Street</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> 692 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension</b>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>July 7, 1956</b> , to <b>July 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1980</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Robert W. Campbell</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>7/21/80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robt W. Campbell</b>	22e ADDRESS <b>Hagerstown Md.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>7-22-80</b>	23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Rest Haven Funeral Chapel, Inc., Hag., Md.</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 24 1980</b>	25b REGISTRAR'S SIGNATURE <i>notary ready</i>		







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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 0 8 2	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. HOUR	
Harlan Phillip Harple		July 21, 1980		11:20 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Sept. 21, 1918	61	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Washington County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Western Maryland Hospital Center		seaman	oil Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
Maryland		Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	353 Central Ave.,	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Arthur P. Harple		Myrtle M. Murray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		216-14-6531	Mrs. Alice Harple, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed.
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) COPD					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from April 16, 19 80, to July 21, 19 80, that (i) (X) last saw the deceased alive on July 21, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (X) did not view the body after death, ( )		22b. SIGNATURE Kyung S. Kim, M.D.		22c. DATE SIGNED 7/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
Kyung S. Kim, M.D.		Western Maryland Hospital Center 1500 Pennsylvania Ave., Hagerstown, Md.		JUL 23 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		July 24, 1980	Shantown Cemetery	Big Pool. dMd.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, MD.		JUL 23 1980		[Signature]	

Date		Description		Amount	
1944	10	...	...	...	...
1944	11	...	...	...	...
1944	12	...	...	...	...
1945	1	...	...	...	...
1945	2	...	...	...	...
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1945	4	...	...	...	...
1945	5	...	...	...	...
1945	6	...	...	...	...
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1945	8	...	...	...	...
1945	9	...	...	...	...
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1945	11	...	...	...	...
1945	12	...	...	...	...
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1950	11	...	...	...	...
1950	12	...	...	...	...

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 8 3	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Homer Leroy Hartranft</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>July 26, 1980</i>			2b. HOUR M			
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 12, 1907</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>clerk</i>		12b KIND OF BUSINESS OR INDUSTRY <i>pharmacy</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>532 Salem Ave.</i>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>Jacob L. Hartranft</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE Holsinger</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-09-1933</i>		17 INFORMANT ADDRESS <i>Genevieve Hartranft Item # 13 Above</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> (c) <i>Generalized Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>year</i> <i>year</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Heart Disease</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <i>July 19 78</i> to <i>July 26 19 80</i> that (I) (we) last saw the deceased alive on <i>July 25 19 80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE <i>Edward Moody</i>				DEGREE				22c DATE SIGNED <i>7/2</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>July 30, 1980</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown WASHINGTON MD</i>					
24 FUNERAL DIRECTOR NAME <i>Osborne Funeral Home P.O. Box 348 Wmspt., MD</i>				ADDRESS		25a DATE RECEIVED BY REGISTRAR <i>AUG 5 1980</i>		25b REGISTERED			

BP



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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Ellen Heckman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 17, 1980</b>		2b. HOUR <b>6:15 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>October 24, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vaughn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Bowders</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-18-2031</b>		17. INFORMANT ADDRESS <b>Herbert C. Heckman, 124 S. Locust St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphocytic Lymphoma with severe</b> DUE TO, OR AS A CONSEQUENCE OF <b>liver and pleural involvement</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/80</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from <b>July 16, 1980</b> to <b>July 17, 1980</b> , that (we) lost saw the deceased <b>July 16, 1980</b> , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not) view the body after death.					
22b. SIGNATURE <b>Robert Brull</b>		22c. DATE SIGNED <b>7/18/80</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Brull, MD</b>	
22e. ADDRESS <b>1198 Kenly Avenue Hagerstown, MD 21740</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-19-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Md.</b>		23e. DATE RECEIVED BY REGISTRAR <b>JUL 22 1980</b>		23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rest Haven Funeral Chapel, Inc., Hag., Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 8 5			
1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Rosezetta ANN HOCKENBERRY								7 1 80		8 52		A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		April 11, 1940		40		YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA				Washington County, MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital						Seamstress		Clothing Factory			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13r. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Path Valley Road					
PA.		Franklin		Fannettsburg									
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Benjamin S. Naugle				Kathryn Geyer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT				ADDRESS			
No				194-28-9485		Ervin E. Hockenberry				17221 Fannettsburg, Pa.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIO PULMONARY ARREST</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1977													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Pulmonary Embolus</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Malignant Melanoma to Liver</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>6-11</u> 19 <u>80</u> to <u>6-30</u> 19 <u>80</u> , that (I) (the hospital) saw the deceased alive on <u>6-30</u> 19 <u>80</u> , and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Mary E. Money, MD.										7-1-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22r. ADDRESS									
Mary E. Money, MD				1708 OAK HILL AVE.				HAGERSTOWN, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE			
Burial				4 July 1980		Path Valley Cemetery		Dry Run, Franklin Co., PA.					
24 FUNERAL DIRECTOR NAME				25 DATE REC'D. BY REGISTRAR				25a. REGISTRAR'S SIGNATURE					
John L. Agett				JUL 8 1980				[Signature]					
24 ADDRESS				25b. REGISTRAR'S SIGNATURE									
John L. Agett Funeral Home				Dry Run, PA 17220									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) James Ralph Holder					2. DATE OF DEATH July 7 30'80		2b. HOUR 4:30 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 1, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		15. KIND OF BUSINESS OR INDUSTRY Drug Co.	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Washington 16c. CITY OR TOWN Hagerstown					17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 50 W. Hillcrest Rd.		
19. FATHER'S NAME Emmanuel Holder					20. MOTHER'S MAIDEN NAME Roberta Thompson				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					22. SOCIAL SECURITY NO 577-05-5202		23. INFORMANT ADDRESS Mrs. Edith Holder Hag. Md.		
24. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF: b) (Original site not determined) DUE TO, OR AS A CONSEQUENCE OF: c) ( ) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Asystole									
25. DATE OF OPERATION 6/23/80		26. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of femur				27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) X					
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) X		34. LOCATION STREET CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.					
35. I certify that (I) (this hospital) attended the deceased from June 8, 1980, to July 31, 1980, that (I) (we) last saw the deceased alive on 7/30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE B. B. Kneisley, M.D.					37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 7/31/80		
39. PHYSICIAN'S NAME (TYPE OR PRINT) B. B. KNEISLEY					40. ADDRESS 148 W. WASH. ST. HAGERSTOWN MD.				
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		42. DATE Aug. 1, 80		43. NAME OF CEMETERY OR CREMATORY Old Brownsville		44. LOCATION CITY OR TOWN COUNTY STATE Brownsville Wash. Md.			
45. FUNERAL DIRECTOR Donald E. Thompson Thompson Funeral Home, Clearspring, Md.					46. DATE REC'D. BY REGISTRAR AUG 5 1980		47. REGISTRAR'S SIGNATURE M. J. M. M.		

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Table 11



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 7 0 8 7

1 - FOR  
STATE  
REGISTRAR

REG. NO

1. DECEASED NAME (TYPE OR PRINT) Susanne (NMI) HOLLAND			7a. DATE OF DEATH MONTH DAY YEAR 7-25 80		7b. HOUR 2:30 A.M.
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR May 6, 1904	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler	12b. KIND OF BUSINESS OR INDUSTRY Victor Pro. Corp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST James Kemper Leigh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lee Thomas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-12-0013	17 INFORMANT ADDRESS Ivan J. Holland 200 S. Conococheague St.		
18 CAUSE OF DEATH (Enter only one cause per line, and (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto - Cervical-vertebral Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-10-79</u> 19 <u>80</u> to <u>7-24</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-23-80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>E. L. Lardner</u>		DEGREE		22c. DATE SIGNED <u>7-25-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. L. Lardner</u>		22e. ADDRESS <u>382 South Cleveland, Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>July 28, 1980</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Clean Spring Washington MD</u>
24 FUNERAL DIRECTOR NAME <u>Major M. Osborne</u>		24b. ADDRESS <u>Williamsport, MD 21795</u>			
25a. DATE REC'D. BY REGISTRAR <u>AUG 5 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



Handwritten text, possibly a signature or name, appearing upside down.

Handwritten number '20'.

Handwritten text at the bottom of the page, possibly a date or reference number.

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				19088															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2e. DATE KNOWN OF DEATH ESTI- MATED		MONTH		DAY		YEAR		2f. HOUR					
Kenneth Eugene Hutzell Sr.		1922		58		YRS.		July 19		19		80		6		45					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
male		white		Jan. 29, 1922		58		MONTHS		DAYS		HOURS		MIN.		July 19		19		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		U.S.A.				Washington		Williamsport		22 Hoffman Dr.		machinest-body		Fairchild		Maryland		Washington		Williamsport	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
Elmer		Ethel		yes		213-16-0673		Margaret E. Hutzell		4292		Flamed									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22g. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22g. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22g. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		22g. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
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FEBRUARY 2 1907

Handwritten notes and faint printed text, mostly illegible due to fading and bleed-through.

Handwritten notes, possibly a list or ledger entries, including some numbers and symbols.



Handwritten signature or name, possibly "R. L. ...", written in a cursive style.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 0 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roger Albert HUTZELL				2a. DATE OF DEATH MONTH DAY YEAR July 3, 1980		2b. HOUR 5:20A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clevelandtown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Truck Mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Boonsboro				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 112 S. Main St.	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Hutzell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Beachley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-14-2318		17. INFORMANT ADDRESS Mrs. Virginia M. Hutzell, 112 S. Main St. Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESP ARREST</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHogenic CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WITH METASTASIS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/80</u> to <u>7/1/80</u> , that (I) (we) last saw the deceased alive on <u>7/1/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>L. Dwight Wooster</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Dwight Wooster, M. D.				22e. ADDRESS 1825 Howell Rd., Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-5-80		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE RECEIVED BY REGISTRAR JUL 8 1980	
						25b. REGISTERED SIGNATURE <u>Barry A. Harty</u>	



July 3, 1950

200. 55, 1950

Cleveland, W. H. H.

Washington County, Ohio

Washington Township

115 S. Main St.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

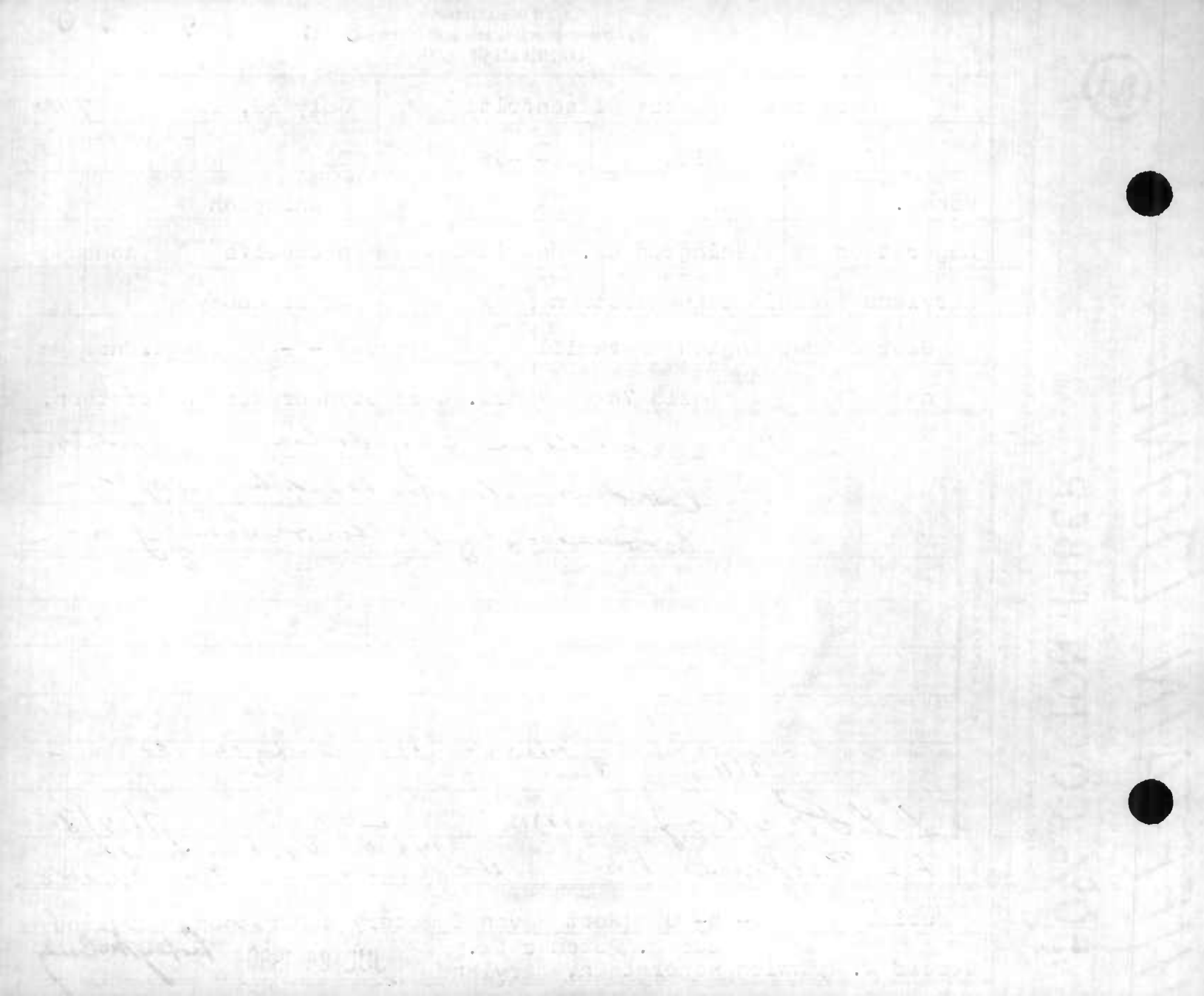
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>Margaret Rebecca Ilgenfritz</b>					2a. DATE OF DEATH MONTH <b>July</b> DAY <b>12</b> YEAR <b>1980</b>			2b. HOUR <b>7:40</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>6</b> YEAR <b>96</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>42 Broadway</b>		
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>					
14 FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Washington</b> LAST <b>Parkhill</b>					15 MOTHER'S MAIDEN NAME FIRST <b>Rebecca</b> MIDDLE <b>-</b> LAST <b>Bomgardner</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>213 74 0847</b>		17 INFORMANT ADDRESS <b>Mrs. Carl Stonebraker Hagerstown, Md</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Due to or as a consequence of</b> <b>Arteriosclerotic heart disease</b> (c) <b>Due to or as a consequence of</b> <b>Generalized atherosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 31</b> , to <b>July 12</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>L.L. Packard</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/14/80</b>			
23a PHYSICIAN'S NAME (TYPE OR PRINT) <b>L.L. Packard MD</b>				22e ADDRESS <b>145 W. Washington St Hagerstown Md 21240</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-15-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown</b> COUNTY <b>Md</b> STATE <b>Md</b>		23e. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>	
24 FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>		ADDRESS <b>305 N. Potomac St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN FILING OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PART 1 OF THIS CERTIFICATE FOR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19091	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Rudolph						Johnson		XX 7 4 1980		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Black	2 14 34		46 YRS.		MONTHS DAYS HOURS MIN.				7 6 1980 1:00 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.						Washington County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Rm. 339 Hamilton Hotel									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Wash		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rm. 339 Hamilton Hotel			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Clint				Johnson				Inez			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				188-30-2616		Robert Johnson		Alexandria, VA 3647 Edison Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7999 IMMEDIATE CAUSE (a) <u>Undetermined</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER		DATE SIGNED	
Thomas D. Smith, M.D.				Deputy Chief						7-7-80	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas D. Smith, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		7/11/80		King Memorial Park		Baltimore		County		MD	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS						JUL 10 1980		Rickey McCreedy			
Wm. C. March F.H. 1101 E. North Avenue											

BP

DHMH - 17  
(VR AT 15 ME (5))  
15M 7/77

EXAMINE & SIGN (UPON DELIVERY)

100% COTTON



JUL 10 1980

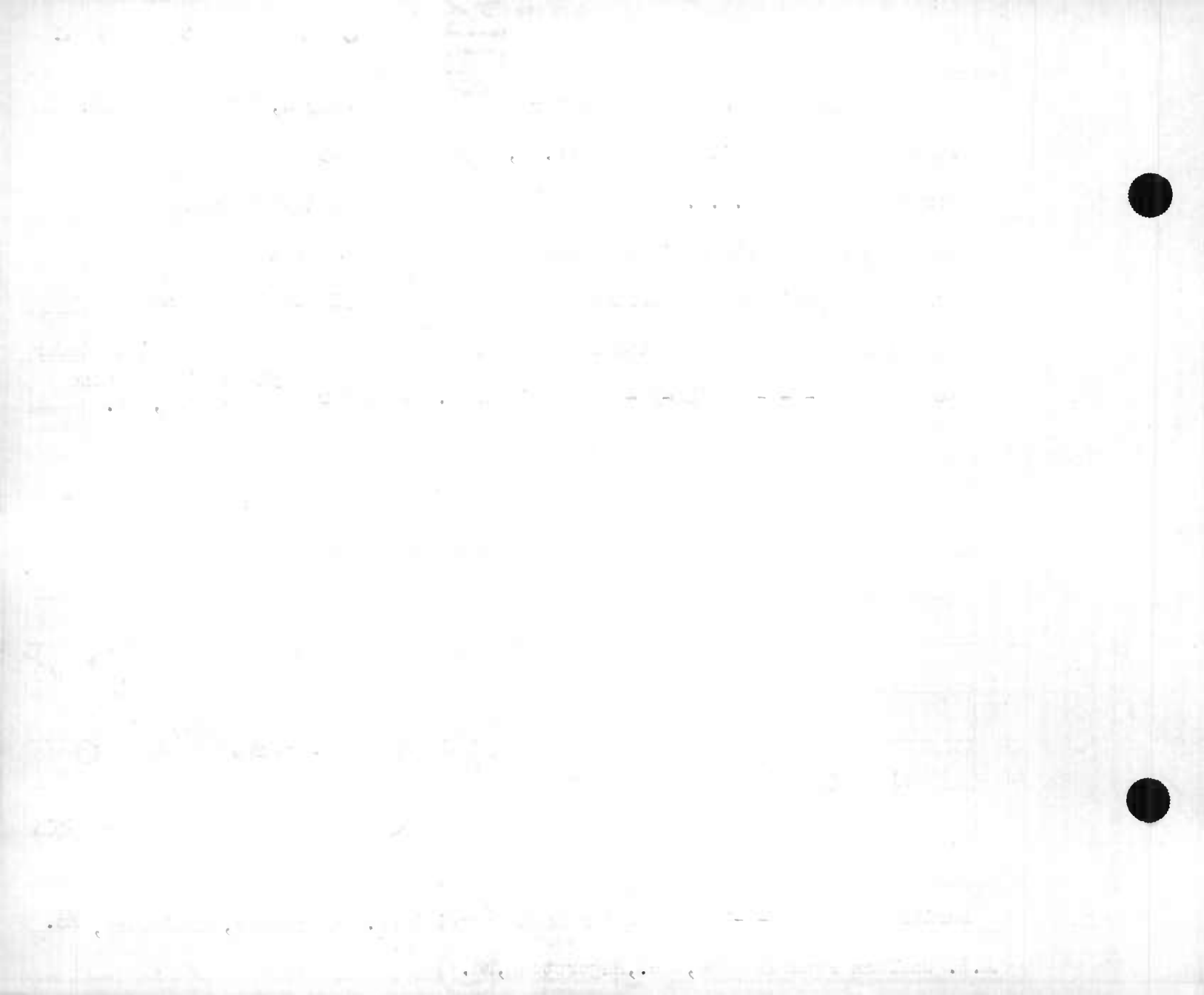
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 0 9 2	
1 - FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Sylvia Jean Keefauver</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 4, 1980</b>				2b. HOUR <b>12:20A</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 8, 1936</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>51 Nottingham Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>51 Nottingham Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Settles</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Diffendafer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-30-9265</b>		17. INFORMANT <b>Wilbur L. Keefauver</b>		ADDRESS <b>51 Nottingham Road Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal carcinomatosis.</b> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma, ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>5-30</b> , 19 <b>80</b> , to <b>6-15</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>6-15</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. Hawbah</b>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-7-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-8-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 10 1980</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>				ADDRESS				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>Edith C Kern</b>					2a DATE OF DEATH MONTH <b>July</b> DAY <b>4</b> YEAR <b>80</b>		2b HOUR <b>10 1/4 AM</b>		
3 SEX <b>7</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>13</b> YEAR <b>1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7 UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>10</b> HOURS <b>10</b> MIN <b>10</b>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		9 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH <b>WASH. Co., MD.</b>			
12 CITY OR TOWN OF DEATH <b>Maugansville</b>		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mennonite Old Peoples Home</b>				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housekeeper</b>		15 KIND OF BUSINESS OR INDUSTRY <b>home</b>	
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Pa.</b>		17 COUNTY <b>Franklin</b>		18 CITY OR TOWN <b>Greencastle</b>		19 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20 STREET ADDRESS <b>265 N. Carlisle St.</b>	
21 FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Cuppett</b> LAST <b>Cuppett</b>		22 MOTHER'S MAIDEN NAME FIRST <b>Zadie</b> MIDDLE <b>Beerbower</b> LAST <b>Beerbower</b>		23 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		24 SOCIAL SECURITY NO <b>218-30-9129</b>		25 INFORMANT ADDRESS <b>Mrs. Geo. L. Burkett - Greencastle, Pa.</b>	
26 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140 Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>yes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>yes</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>	
27 DATE OF OPERATION		28 CONDITION FOR WHICH OPERATION WAS PERFORMED				29 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		30 IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
31 ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		32 TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		33 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
34 INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		35 PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		36 LOCATION STREET CITY OR TOWN COUNTY STATE					
37 I certify that (I) [this hospital] attended the deceased from <b>Jun 23</b> , 19 <b>80</b> , to <b>Jun 24</b> , 19 <b>80</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>Jun 24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
38 SIGNATURE <b>Howard W. Weeks</b>				39 DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>				40 DATE SIGNED <b>7/4/80</b>	
41 PHYSICIAN'S NAME (TYPE OR PRINT) <b>H.W. Weeks</b>				42 ADDRESS <b>680 Northern Ave Hazleton, Pa.</b>					
43 BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		44 DATE <b>7/2/80</b>		45 NAME OF CEMETERY OR CRYPTORY <b>Addison Cem.</b>		46 LOCATION CEMETERY COUNTY STATE <b>Addison, Penna.</b>		47	
48 FUNERAL DIRECTOR NAME <b>A.E. Minnich - Greencastle, Pa.</b>				49 ADDRESS <b>Greencastle, Pa.</b>		50 DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		51 REGISTRAR'S SIGNATURE <b>John A. Grady</b>	

BP

Re: Thomas - Greenough, Pa.  
7/1/80 Addison Co. Address Pennsylvania

No. ——— 28-30-121 Mr Geo. L. Burnett - Greenough, Pa.  
Edward Guppert 2nd St Beerdown  
Pa. Franklin Greenough 2nd St N. Gardale St  
Mandaville Thomas Old Poplar House Thomas

U.S.A. X

Sept. 13, 1872



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
REG. NO. 8019094									
1 DECEASED NAME (TYPE OR PRINT) <b>Paul Leroy Keplinger Sr.</b>					2a DATE OF DEATH MONTH DAY YEAR <b>7/14/80</b>		2b HOUR <b>5:30 AM</b>		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3/25/11</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electrician</b>		12b KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>402 Summit Avenue</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Howard C. Keplinger</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lona E. Widdows</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>214-09-8109</b>		17 INFORMANT ADDRESS <b>Thelma A. Keplinger, Hagerstown, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe Organic Heart Disease</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 Mo.</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>MODERATE RENAL FAILURE</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I (this hospital) attended the deceased from <b>Sept 7/13</b> , 19 <b>79</b> , to <b>July 13</b> , 19 <b>80</b> , that (I ( ) saw the deceased alive on <b>7/13</b> , 19 <b>80</b> , and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above, (I ( ) (did not) view the body after death.									
22b SIGNATURE <b>Mary E. Money</b> MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>7/14/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary E. Money, MD</b>				22e ADDRESS <b>1708 OAK HILL AVE, HAGERSTOWN, MD</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>July 16, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				24b ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b REGISTRAR'S SIGNATURE <b>John A. Brady</b>	

BP



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 0 9 5				
1 - FOR STATE REGISTRAR				REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) Evelyn Evelyn May KING			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1980			2b. HOUR 7:20 P <sup>M</sup>		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Technician		12b. KIND OF BUSINESS OR INDUSTRY Rt. Ritchie	
13a. STATE Md.				13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		
14 FATHER'S NAME FIRST MIDDLE LAST Ross - Grove				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Catherine Garnand				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-16-4144		17 INFORMANT ADDRESS Miss Zelda Grove, Smithsburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) metastatic adenocarcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/22/80 to 7/22/80, that (I) (we) lost the deceased alive on above, (I) (we) did not view the body after death.								
22b. SIGNATURE Woolner Mx				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/22/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WOOSTER				22e. ADDRESS 1825 Howard Rd HOGST. MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md.		
24 FUNERAL DIRECTOR NAME Davis Funeral Home, Smithsburg, Md.				25a. DATE REC'D. BY REGISTRAR JUL 29 1980		25b. REGISTRAR'S SIGNATURE Barney McCreedy		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRAR

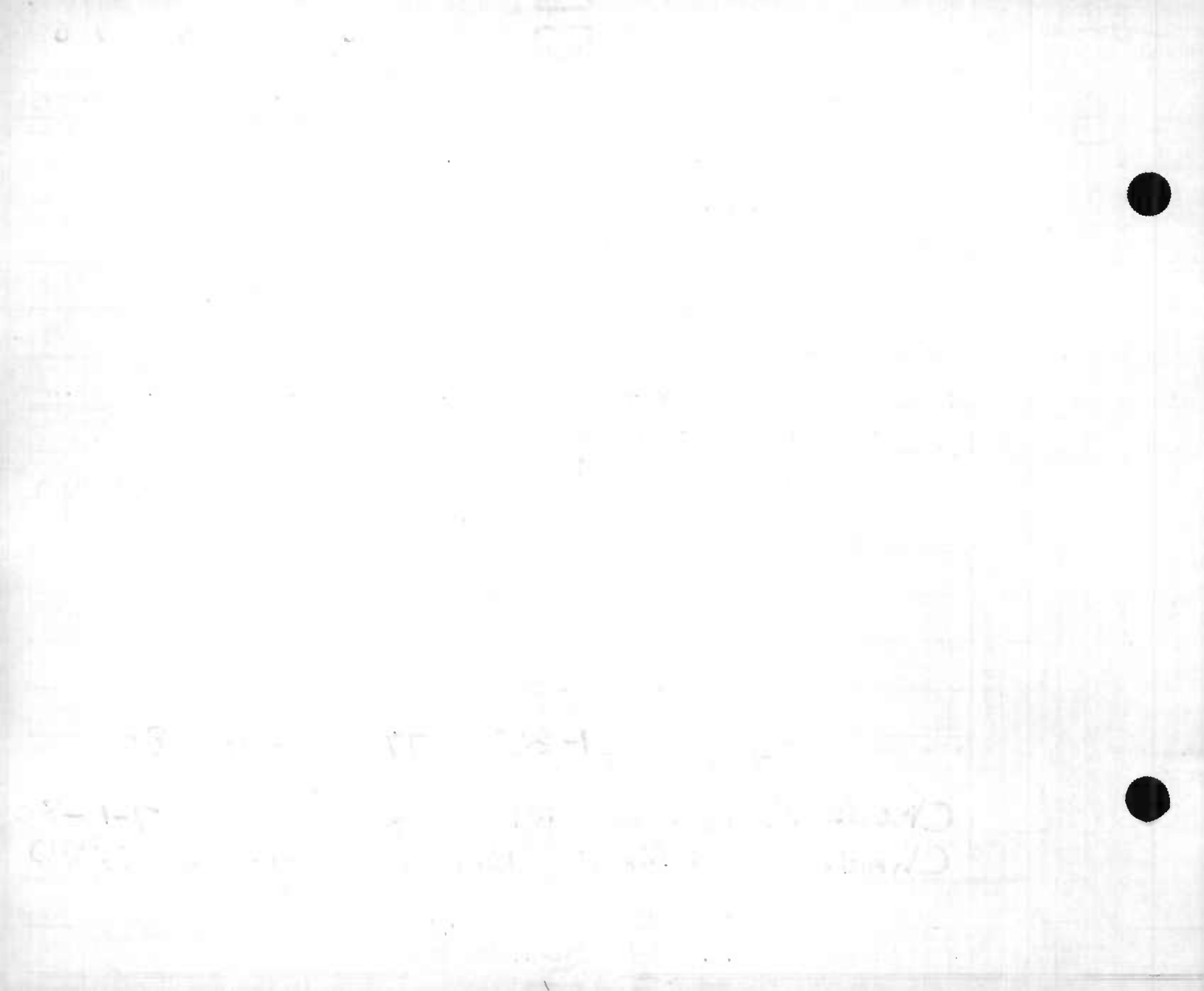
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 9 0 9 6  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie Dorothy Koontz			2a. DATE OF DEATH MONTH DAY YEAR 7 14 80			2b. HOUR 2:55p M				
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR March 4, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George Washington Stratiff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth NMM Reid			13e. STREET ADDRESS 11 Decker Ave.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-1208D			17 INFORMANT ADDRESS George W. Koontz 203 S. Vermont St. Wmspt., MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 3 days years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-25, 19 77, to 7-14, 19 80 that (I) (we) last saw the deceased alive on 7-11, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles R Wierer MD						DEGREE MD		22c. DATE SIGNED 7-1-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R Wierer						22e. ADDRESS Box 173, Myersville MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 17, 1980		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD			
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 343 Wmspt., MD						25. DATE RECORDED BY REGISTRAR JUL 16 1980		26. REGISTRAR'S SIGNATURE		

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 9 0 9 7			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>ANNA NMN LEASURE</b>				2a DATE OF DEATH MONTH DAY YEAR <b>1 July 1980</b>		2b HOUR <b>4:02 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>September 6, 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland State Hosp.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b> 13b COUNTY <b>Washington</b> 13c CITY OR TOWN <b>Hagerstown</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>510 Summit Avenue</b>	
14 FATHER'S NAME (TYPE OR PRINT) <b>William Hunt</b>				15 MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Loretta F. Walls</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO <b>215-36-6312</b>		17 INFORMANT ADDRESS <b>Sarasota, Fla.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> (b) <b>Past CVA</b> (c) <b>Genil AS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 mo</b> <b>years</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-1-80</b> P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (his hospital) attended the deceased from <b>6-4-80</b> to <b>7-1-80</b> , that (I) (we) last saw the deceased alive on <b>7-1-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b SIGNATURE <b>Edwin G. Riby MD</b> DEGREE <b>MD</b>				22c DATE SIGNED <b>7-1-80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edwin G. Riby MD</b>				22e ADDRESS <b>1500 Penna. Hagerstown Md</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>7/3/80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown Wash. Md.</b>		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <b>Rest Haven Funeral Chapel, Inc., Hag., Md.</b> ADDRESS				25a DATE REC'D. BY REGISTRAR <b>JUL 9 1980</b> 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Daniel William Linkins Sr.					REG. NO. 8019098				
1. DECEASED NAME (TYPE OR PRINT) Daniel WILLIAM Linkins SR					2a. DATE OF DEATH MONTH DAY YEAR July 27, 1980			2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 17, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Distric of Columbia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Aircraft	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 151 West Washington Street	
14. FATHER'S NAME FIRST MIDDLE LAST John Linkins					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Lathran				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-01-8747		17. INFORMANT ADDRESS Beverly A. McElroy 128 Ray Street Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Antihistrotic Heart Disease (c) Antihistrotic Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.H. Rander					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-28-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 138 E Antietam St Hagerstown Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-30-80		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.		
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, INC., Hagerstown, Md.					25. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

DATE: 11/11/1911

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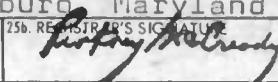
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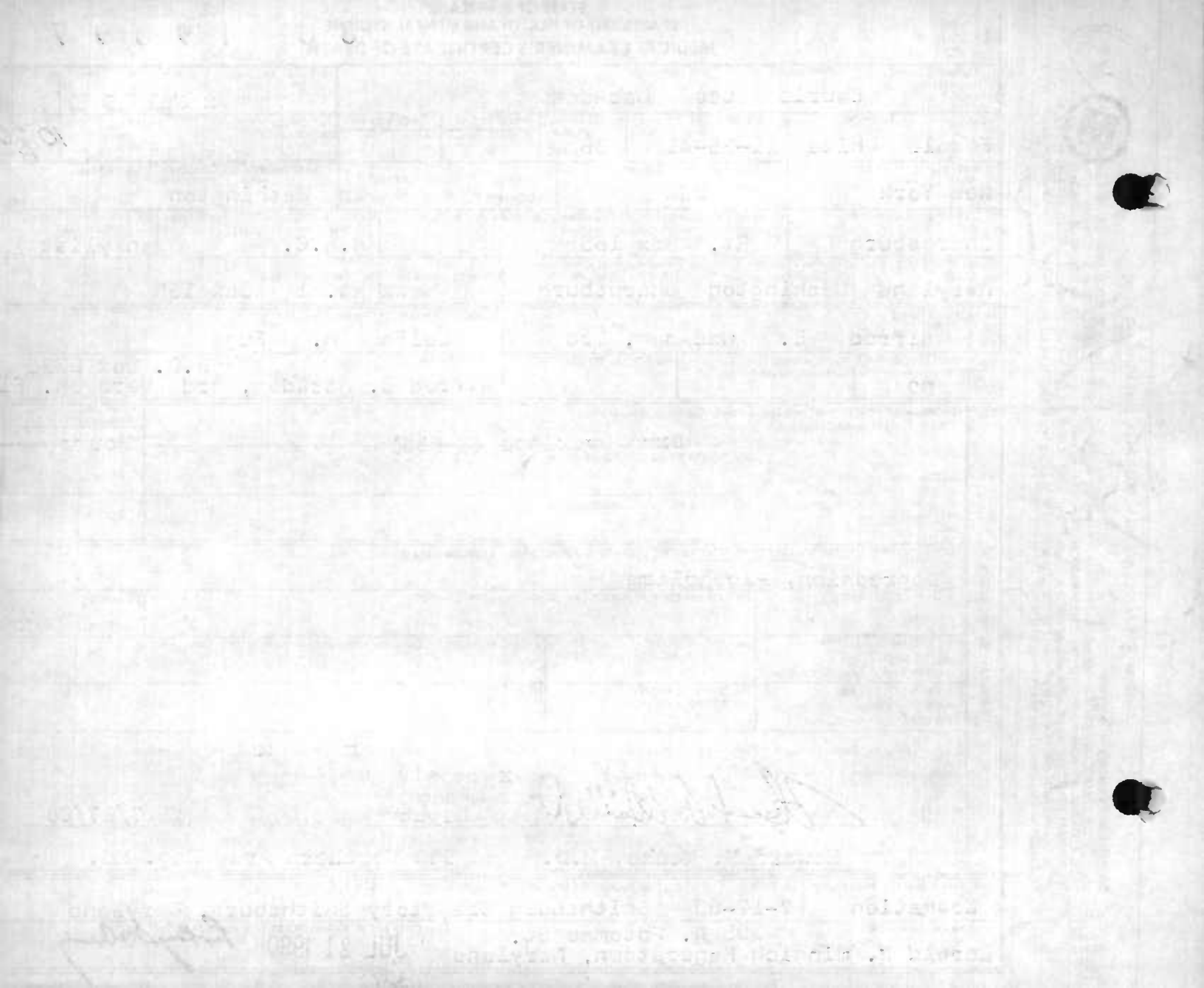
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(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19099		
1. DECEASED NAME (TYPE OR PRINT) <b>Laurie Lee MacAdam</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 15 80</b>		2b. HOUR <b>A</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-25-41</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>38 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>July 15 19 80</b>		2d. HOUR <b>10:20</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>						
10. CITY OR TOWN OF DEATH <b>Sharpsburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. Box 155</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N.R.C.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>anaylist</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Sharpsburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 155</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred E. MacAdam, 3rd</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leila M. Fuge</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>P.O. Box 8326</b> <b>Alfred E. MacAdam, 3rd Vera Bh. Fl</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9505 Drug Overdose (E-950)</b> Canditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Depression, Alcoholism</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>Deputy</b>					DATE SIGNED <b>7/17/80</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Howard N. Weeks, M.D.</b>			ADDRESS <b>580 Northern Ave, Hag. Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>7-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>					ADDRESS <b>305 N. Potomac St.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1980</b>		25b. REGISTRAR'S SIGNATURE 		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 1 0 0
1- FOR STATE REGISTRAR <b>Blanche Mae Mark</b>										REG. NO.
1 DECEASED NAME (TYPE OR PRINT) <b>BLANCHE MAY MARK</b>					2a DATE OF DEATH MONTH <b>JULY</b> DAY <b>25</b> YEAR <b>'80</b>			2b HOUR <b>M</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>March</b> DAY <b>11</b> YEAR <b>1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7a IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7b IF UNDER 24 HRS HOURS <b></b> MIN <b></b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County Maryland MD.</b>				
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>844 Summit Avenue</b>		
14 FATHER'S NAME FIRST <b>Jacob</b> MIDDLE <b></b> LAST <b>Shultz</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Hahn</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>---</b>		17 INFORMANT <b>Rev. David Mark</b>		ADDRESS <b>123 South 10th Street Lebanon, Pa.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>										
19a DATE OF OPERATION <b>NONE</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (1) (this hospital) attended the deceased from <b>JULY 19 19 80</b> to <b>JULY 25 19 80</b> , that (1) (we) lost saw the deceased alive on <b>JULY 24 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.										
22b SIGNATURE <b>Barry M Cohen</b>				DEGREE <b>M.D.</b>				22c DATE SIGNED <b>7-26-80</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY M COHEN</b>				22e ADDRESS <b>1198 KENLY HUE HAGERSTOWN, MD, 21740</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>7-28-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Maryland</b>				
24 FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>				25a DAY AND BY RECEIVED <b>AUG 1 1980</b>		25b RECEIVED BY SIGNATURE <b>[Signature]</b>				

March 11, 1967

Washington County Maryland

Washington County Maryland

Washington County Maryland

Washington County Maryland

Washington County Maryland

Washington County Maryland

AUG 1 1968

Washington County Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE** 8 0 1 9 1 0 1  
**CERTIFICATE OF DEATH**

FOR  
 1 - STATE  
 REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Harry Bertram MARTIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 15, 1980</b>			2b. HOUR <b>M</b>					
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 1, 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		7b. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clearview Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>329 Bryan Place</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Randolph Martin</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Molly V. Kinsel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)			17 INFORMANT ADDRESS <b>Mrs. George Schnurr, Hagerstown, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Central Anoxia</b> <b>4340</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Central Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN.</b> <b>HRS.</b> <b>YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 14, 1980</b> to <b>July 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/16/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>July 18, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>						25a. DATE RECEIVED BY REGISTRAR <b>JUL 21 1980</b>		25b. BY REGISTRAR <b>[Signature]</b>			
415 E. Wilson Blvd., Hagerstown, Md. 21740											





The following is a list of the  
 names of the persons who  
 were present at the meeting  
 held on the 1st of May 1900  
 at the residence of Mr. J. H.

J. H.

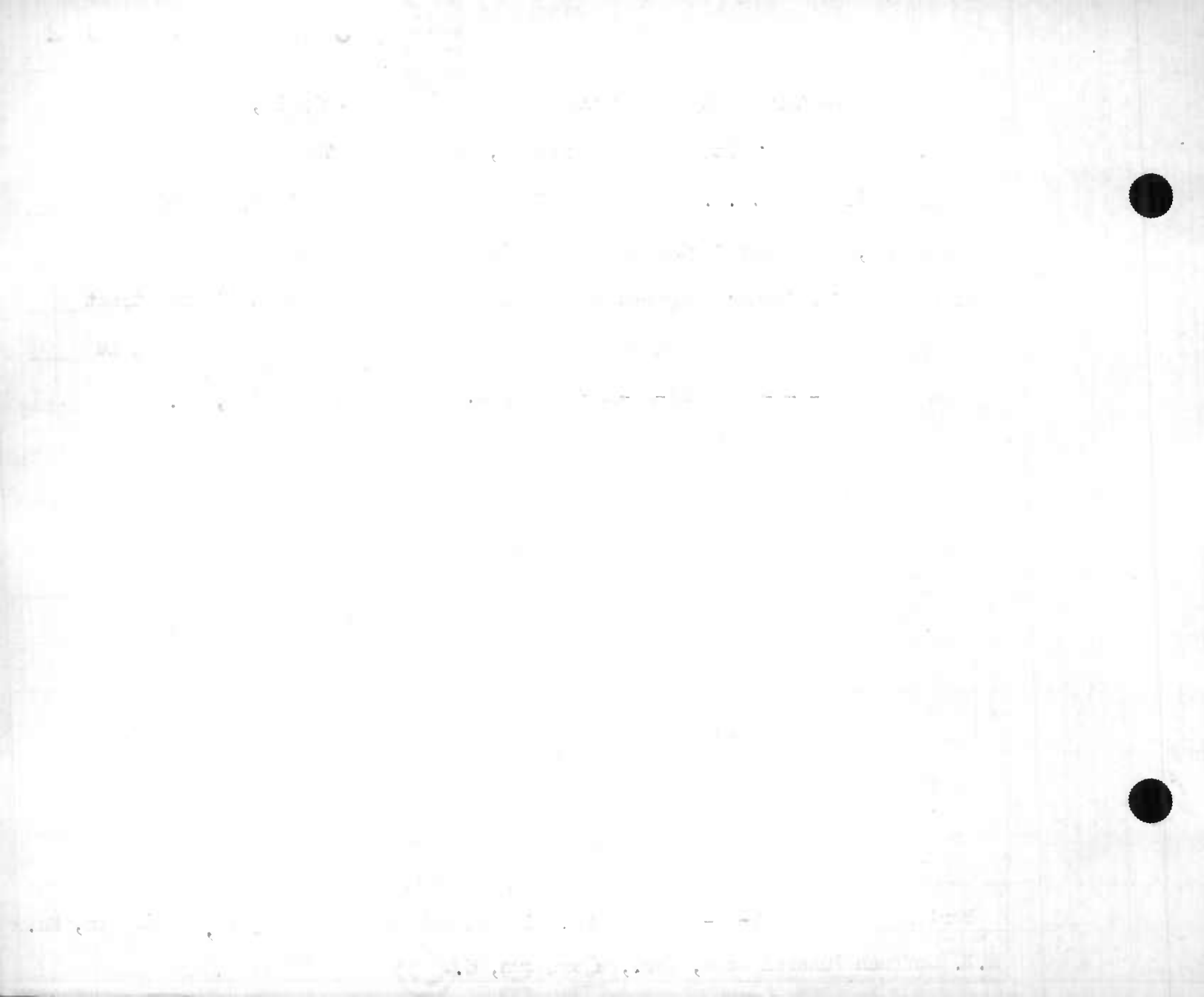


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8019102
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>Lester Boyd Mauck</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1980</b>				2b. HOUR <b>M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 12, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown,</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11 West Baltimore Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Boyd Mauck</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ethel Knable</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-18-1492</b>		17. INFORMANT <b>Carl S. Eby</b>		ADDRESS <b>Route # 1 Box 452 Clear Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerotic vascular disease</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2° burn Rt. burn</b>										
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 6/20 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>Water boiling to 1st foot</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Potomac Town</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20/80</b> to <b>7/19/80</b> , that (I) (we) lost saw the deceased alive on <b>7/18/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>E. H. Oacblondur</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/21/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. H. Oacblondur</b>			22e. ADDRESS <b>Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-22-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clear Spring Church Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clear Spring Washington, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										80	19103
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Albert Newton MILLER							July 28, 1980			3:40P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		May 30, 1908		72		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
85 Morgan Co. W. Va.			U. S. A.						Washington MD		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
79 Hagerstown			Washington County Hospital			Home Builder			Construction		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
35 Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11 W. Baltimore St.			
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
211 Daniel Lafayette Miller						Martha Jane Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
1 NO				219- 05- 2822		Mrs. Lenora I. Miller, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>										hours	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis of Heart Arteries</u>										years	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus and nephrosclerosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
2 None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>1971</u> <u>July 28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Gloria F. Pura						ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>		3/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
GLORIA F. PURA						382 S. CLEVELAND HAGERSTOWN					
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			7-31-80		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.				
24 FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr. Boonsboro, Md. 21713						AUG 1 1980		[Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John H. Harrison, Jr. 1950

John H. Harrison, Jr. 1950

John H. Harrison, Jr. 1950

John H. Harrison, Jr. 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 9 1 0 4  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARLTON LEE MITCHELL		2a. DATE OF DEATH MONTH DAY YEAR July 19, 1980 2b. HOUR M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR March 9, 1913 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 907 Lanvale Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 907 Lanvale Street	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Warren Mitchell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Cox	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 219-20-2193	17 INFORMANT ADDRESS Mrs. Helen R. Mitchell, 907 Lanvale St	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 410- Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b). Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c). 20yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Emphysema; Asthmatic bronchitis			
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR none 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) none	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK none	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none	21f. LOCATION STREET CITY OR TOWN COUNTY STATE -- -- -- -- --	
22a. I certify that (I) (this hospital) attended the deceased from May 19 73, to July 19 19 80, that (I) (we) lost saw the deceased alive on July 16 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE William W. Lesh M.D.		22c. DATE SIGNED 7-21-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.		22e. ADDRESS 411 Division Ave Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-22-80	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.
24 FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md		25a. DATE REC'D. BY REGISTRAR JUL 24 1980 25b. REGISTRAR'S SIGNATURE [Signature]	

William W. Nash W.D. 441 Division Ave Haverstown, Md.

08-15-80 x W.H.W.L. re

-----

none none none none none none

July 16 80 July 19 79 July 19 80

-----

None	-----	X	X	Emphysema; Asthmatic bronchitis
------	-------	---	---	---------------------------------

minutes  
Acute myocardial infarction

20 yrs  
Coronary atherosclerosis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 9 1 0 5 CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>Paul Edward Moats</b>					2a DATE OF DEATH MONTH <b>7</b> DAY <b>10</b> YEAR <b>80</b>			2b HOUR <b>409</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>4</b> YEAR <b>1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Excavating</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>402 Linganore Avenue</b>		
14 FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>E.</b> LAST <b>Moats</b>					15 MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE <b>Miller</b> LAST <b>Miller</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO <b>WW II</b>		17 INFORMANT ADDRESS <b>Mrs. Phyllis Moats, 402 Linganore</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Refractory hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>7/10/80</b> , 19 <b>80</b> , to <b>7/10/80</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/10/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frederic A. Kass</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/10/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic A. Kass M.D.</b>				22e. ADDRESS <b>1825 Howell Rd Hagerstown Md</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-12-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown</b> COUNTY <b>Wash.,</b> STATE <b>Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Rest Haven Funeral Chapel, Inc.,</b> ADDRESS <b>Hag., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL - 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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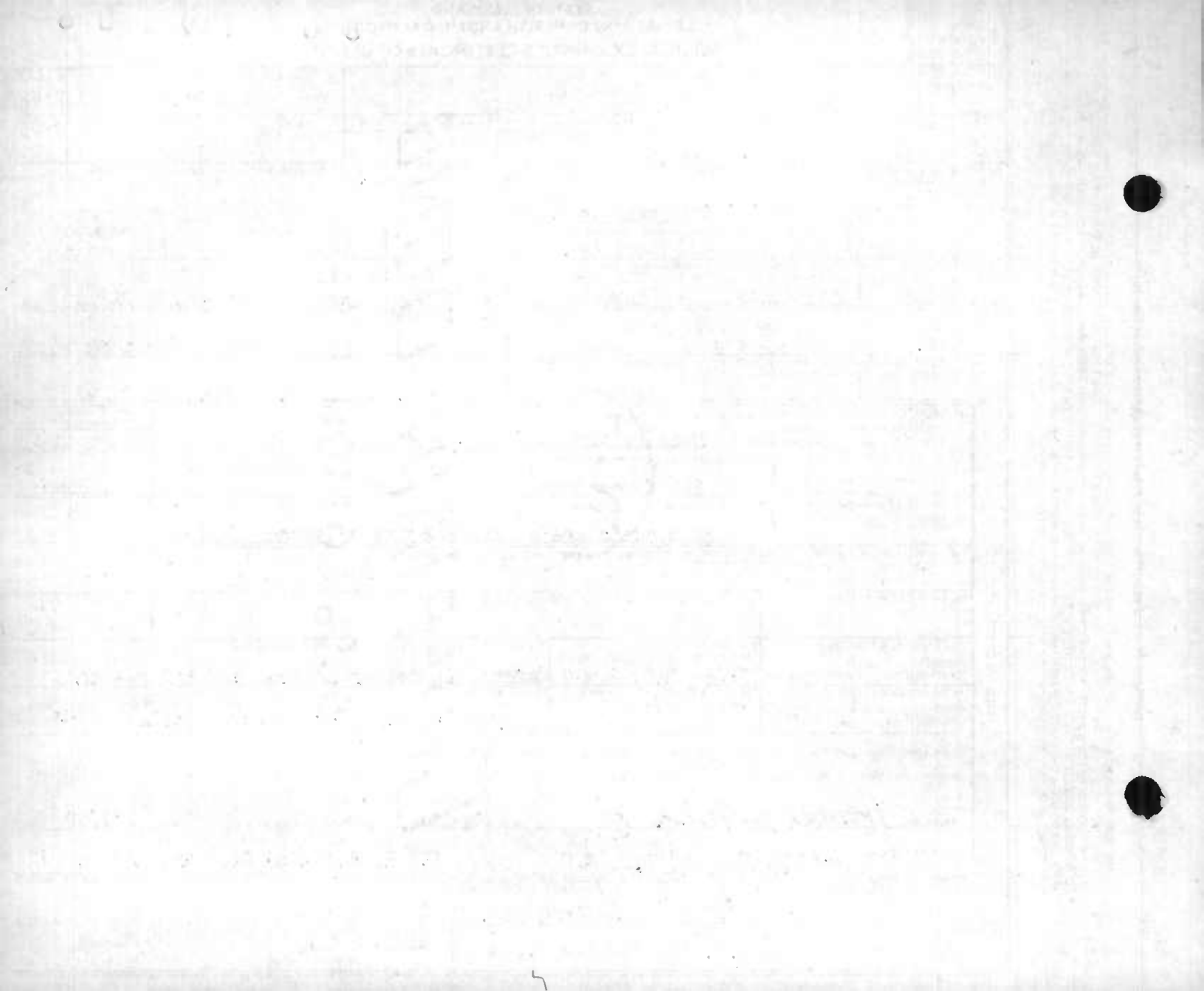




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19106	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Roy Erwin Moats</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 6 1980</b>		2b. HOUR <b>7:45 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1961</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>19 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>July 6 1980</b>		2d. HOUR <b>8:45 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hopewell Road Hag., MD 21740</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington</b>		13c. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Rt. 4 Hagerstown, MD 21740</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Gordon Moats</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Katherine Murray Slater</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>James G. Moats Rt. 4 Hag., MD 21740</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive head injuries N-854</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Skull fracture N-803</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Motor cycle losing control ran off road E-816</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>seconds</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:45 M. July 6 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Motorcycle losing control and ran off road</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Hopewell Road Hagerstown Wash. MD</b>							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Harold R. Tritch, Jr.</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER				DATE SIGNED <b>7/7/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R. Tritch, Jr., M.D.</b>		ADDRESS <b>138 E. Antietam St., Hagerstown, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>July 9, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Osborne Funeral Home P.O. Box 348 Wmspt., MD</b>		25a. DATE REC'D BY REGISTRAR <b>JUL 16 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

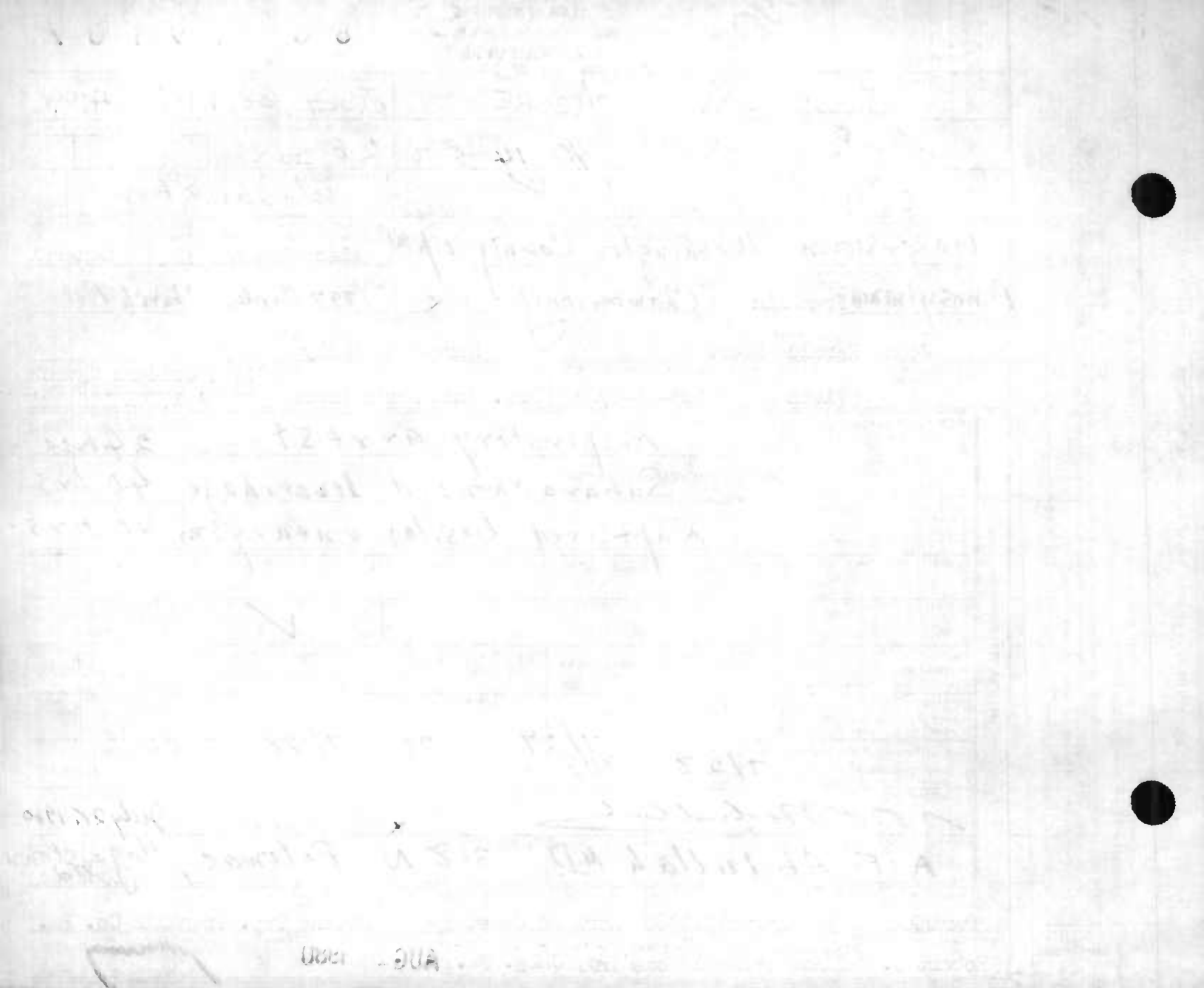
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8019107	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JESSE W. MOORE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 28, 1980</b>		2b. HOUR 4:08 PM
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 53</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>26 Yrs</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S. D.C.</b>		7a. CITIZEN OF WHAT COUNTRY? <b>U.S. D.C.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, CITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>	
13a. STATE <b>Pennsylvania</b>		13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Chambersburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Harold Moore</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Emily Boyer</b>		17. INFORMANT ADDRESS <b>797 Criders Church Road, Chambersburg, Pa. 17201</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Vietnam</b>		16b. SOCIAL SECURITY NO. <b>205-44-0929</b>		17. INFORMANT ADDRESS <b>797 Criders Church Road, Chambersburg, Pa. 17201</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory arrest.</b> 430- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Subarachnoid hemorrhage</b> (c) <b>Ruptured basilar aneurysm</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>40 hrs</b> <b>40 hrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> 19 <b>80</b> to <b>7/28</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A.F. Abdullah</b>		DEGREE		22c. DATE SIGNED <b>July 28, 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.F. Abdullah M.D.</b>		22e. ADDRESS <b>318 N. Potomac, Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>August 1, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>	
23d. LOCATION (CITY OR TOWN) <b>Greene Twp. Franklin Co. Pa.</b>		23e. COUNTY <b>Franklin</b>		23f. STATE <b>Pa.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert G. Sellers</b>		ADDRESS <b>Sellers Funeral Home Inc, Chbg. Pa.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG - 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 1 9 1 0 8	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Preston Miller Mowen		July 24 1980		800 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	August 23, 1896	83 YRS.	Washington MD	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	11. IF UNDER 1 YEAR	12. IF UNDER 24 HRS	
Maryland	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTHS	HOURS MIN.	
13. CITY OR TOWN OF DEATH	14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	15. USUAL OCCUPATION		16. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington Co Hospital	Blacksmith		Railroad	
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18. INSIDE CITY LIMITS?		19. STREET ADDRESS	
17a. STATE		17b. COUNTY		17c. CITY OR TOWN	
Penna.	Franklin	Greencastle		30 West Baltimore St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
Martin L. Mowen		Sarah Rebecca Hartman			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INFORMANT	
no		705-10-6601		Ray W. Mowen	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Disseminated Carcinoma					
(Type undetermined)					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):					
Congestive heart failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		CITY OR TOWN COUNTY STATE	
AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from 7-21 1980 to 7-24 1980, that (I) (we) last saw the deceased alive on 7-24 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Charles C. Spencer		M.D.		7-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>		22e. ADDRESS	
Charles C. Spencer				1198 Kenly Ave Hagerstown 21740	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7/28/1980		Cedar Hill Cemetery	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
David H. Zimmerman		Greencastle, Pa.		JUL 28 1980	
25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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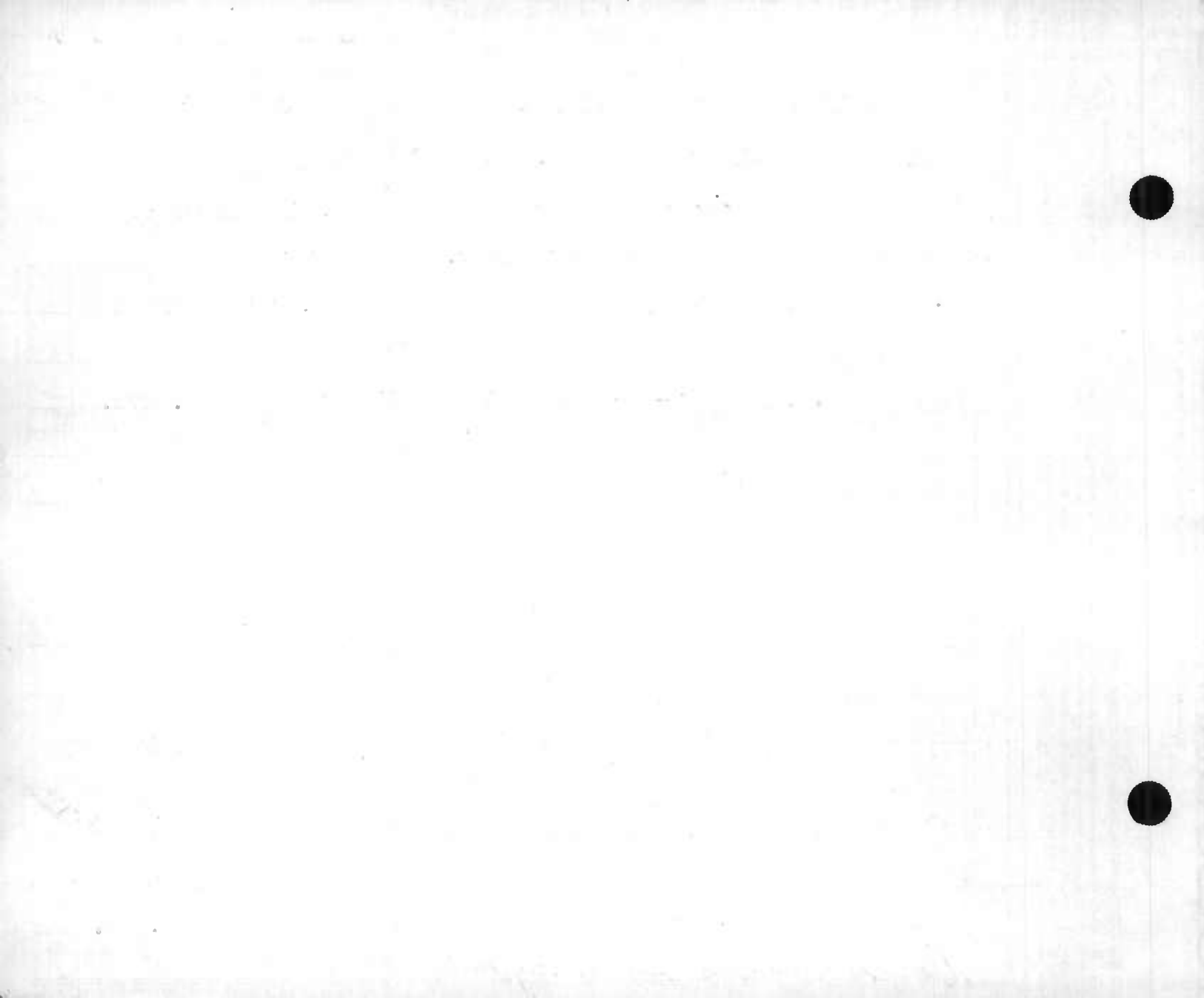
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 1 0 9	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH								
1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR			REG. NO.		
Julian NMN Offray			July 4 1980			2:15A					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a MONTH		7b YEAR	
Male		Black		Dec. 12 1910		69					
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 MONTHS		11 DAYS	
Unknown		U.S.A.				Washington County					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hosp.		Laborer							
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		
Unknown			Unknown			Yes			W.W. 2 438-03-9435		
17 INFORMANT			18 ADDRESS			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		
Luvinia Sullivan			605 Penn. Ave.								
11 CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>and Arterio Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> 2 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
20a DATE OF OPERATION			20b AUTOPSY?			20c IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>80</u> to <u>7/4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			22c DEGREE			22d DATE SIGNED					
Donald E Martin			MD			2/2/80					
22e PHYSICIAN'S NAME (TYPE OR PRINT)			22f ADDRESS			22g ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
DONALD E MARTIN MD			363 S Cleveland Ave Hagerstown								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE		
Burial			Jul. 10-80			Rose Hill Cem. Hagerstown Wash. Md.					
24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Dennis R. Davis			JUL 10 1980								





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 1 1 0	
1- STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) <b>Josephine A. Ogle</b>					2a DATE OF DEATH MONTH DAY YEAR <b>07 30 80</b>				2b HOUR <b>927 AM</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 31 - 04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Avalon Manor, Inc.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>home</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>Washington</b> CITY OR TOWN <b>HAGERSTOWN</b>					13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS <b>138 Langhorn Blvd.</b>				
14 FATHER'S NAME FIRST <b>Clarence</b> MIDDLE <b>Randolph</b> LAST <b>Lyon</b>					15 MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b>-</b> LAST <b>Morrissey</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b SOCIAL SECURITY NO <b>215 48 8290</b>		17 INFORMANT ADDRESS <b>Mrs. Virian Ogle see #13</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RHEUMATOID ARTHRITIS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>long stand</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEVERE - CRIPPLING</b>										<b>ing</b>	
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>POORLY NOURISHED</b>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>7/30</b> 19 <b>80</b> , to <b>7/30</b> 19 <b>80</b> , that (I) (we) lost above. (I) (we) did (did not) view the body after death.											
22b SIGNATURE <b>Chambers</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/1/80</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. R. Amarillo</b>					22e ADDRESS <b>127 King St. Hagerstown, Md.</b>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>7-31-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Gerald N. Minnick</b> ADDRESS <b>305 N. Potomac St. Hagerstown, Maryland</b>					25a DATE REC'D. BY REGISTRAR <b>AUG 11 1980</b>			25b REGISTRAR'S SIGNATURE <b>Henry Melody</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 1 1 1			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR			
Mary Jean Packer				7-4-80			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		June 10, 1917		63 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.				Washington	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		1400 Indian Lane		housewife			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS	
Maryland Washington Hagerstown						1400 Indian Lane	
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Thomas W. Trembath				Mary Shullenberger			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
no		199-07-4614A		Dr. Lawrence L. Packer, Jr. Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardio-respiratory arrest							immediate
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease							years
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis							years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Diabetes Mellitus							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from June 9, 1980, to July 4, 1980, that (II) (we) last saw the deceased alive on July 2, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
W. S. Hood		MD				7-5-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
W. S. Hood				645 East First St., Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Cremation		July 8, 1980		Smithsburg Crematorium		Smithsburg Wash., Maryland	
24 FUNERAL DIRECTOR (NAME)				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740				JUL 11 1980		Petry, Halvord	

1911 JUL 11

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1911 JUL 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 1 1 2	
1. FOR STATE REGISTRAR				REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) <b>PAULSGROVE, MORRIS STECK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>7/25/80</b>				2b. HOUR <b>4:30 P.M.</b>			
3 SEX <b>MALE</b>		4 RACE <b>Can.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 5 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Beaver Creek, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON, MD.</b>					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH. CTY. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roads Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Co. Roads Dept.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Smithsburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rfd. 2</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christian Paulsgrove</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hanna Frey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>215-18-1168A</b>		17. INFORMANT ADDRESS <b>12507 Brandenburg Hollow Rd. Mrs. Mabel C. Stotemyer, Myersville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anteroselectic Heart Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-25-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William N. Fender, M. D.</b>				22e. ADDRESS <b>138 E. Antietam St., Hagerstown, Md. 21740</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>7-28-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1980</b>		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

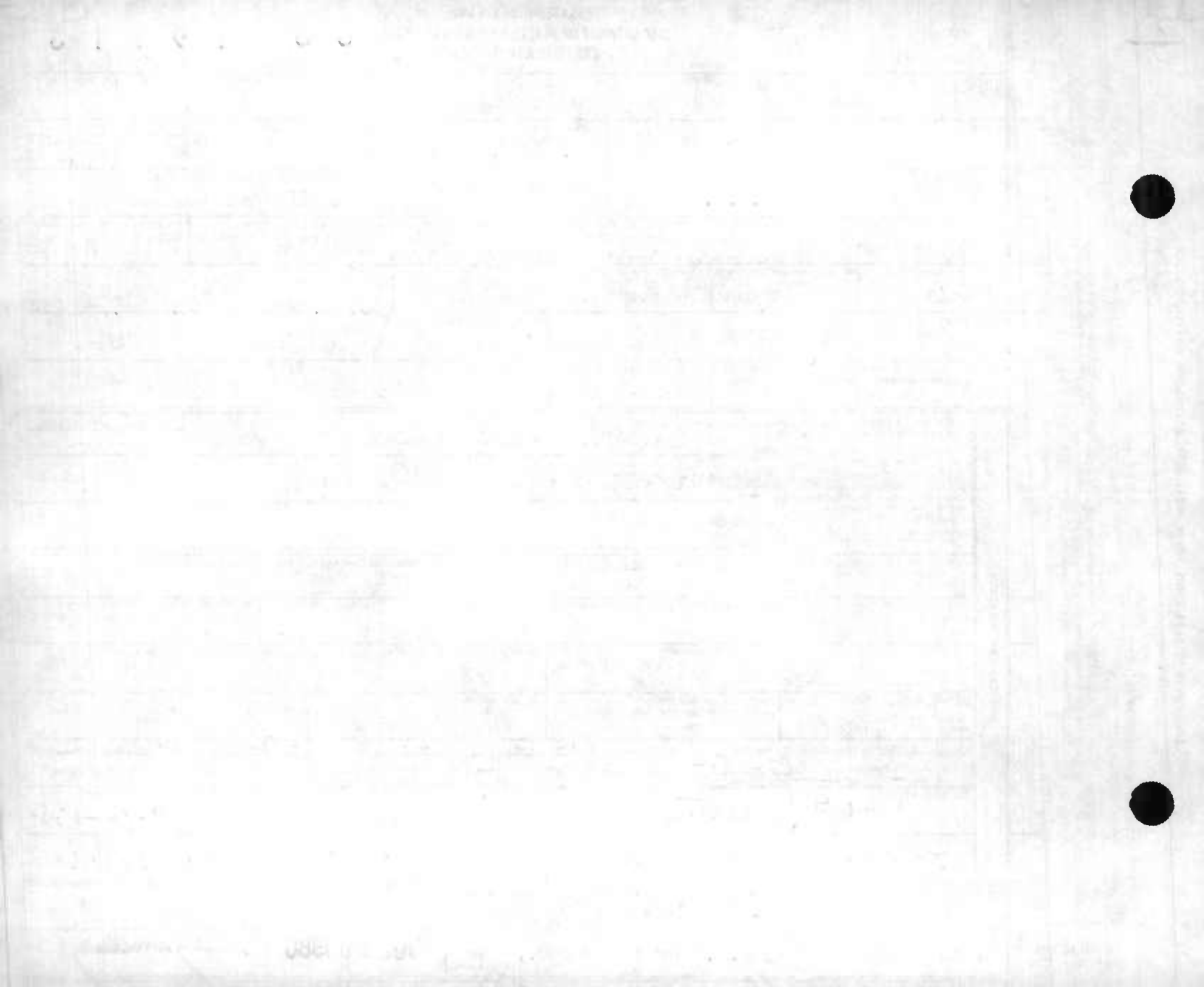
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	9	1	1	3
1. FOR STATE REGISTRAR						REG. NO.										
1 DECEASED NAME (TYPE OR PRINT) Clarence MNN Poffenberger						2a DATE OF DEATH MONTH DAY YEAR July 9, 1980				2b HOUR M						
3 SEX male			4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1910			6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
10 CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler			12b. KIND OF BUSINESS OR INDUSTRY Victor Products				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 751 S. Patomac St. Hagerstown, MD 21740								
14 FATHER'S NAME FIRST MIDDLE LAST Owen Edward Poffenberger						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Elizabeth Jones										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 220-16-3145			17 INFORMANT Cleo Poffenberger			ADDRESS Item # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbine am by the as 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Anterior-inferior Lead 5 feet Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours years																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that (I) (this hospital) attended the deceased from 1-11-1967 to 7-9-1980, that (I) (we) last saw the deceased alive on 7-9-1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE John F. Henderson						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 7-10-1980						
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECONDARI						22e ADDRESS Boonsboro Rd 21713										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/13/80		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery			23d LOCATION CITY OR TOWN Keedusville		COUNTY Washington		STATE MD				
24 FUNERAL DIRECTOR Osborne Funeral Home P.O. Box 348 Wmspt., MD						25a DATE REG'D BY REGISTRAR JUL 16 1980		25b REGISTRAR'S SIGNATURE [Signature]								

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 0 1 9 1 1 4				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Mabel Virginia REEL					MONTH DAY YEAR July 30, 1980				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
female		white		MONTH DAY YEAR December 17, 1899		80		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Hagerstown, Md.		USA				Washington		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Route 2				Sewing mac op.		dress mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Hagerstown					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 2		
14 FATHER'S NAME FIRST MIDDLE LAST George W. Row					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie M. Munday				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES					16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS		
no					218-01-0976		John W. Reel, Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>CARDIORESP. ARREST.</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRCUMSTANCES OF PLASPER</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
L. Dwight Wooster		M.D.						7/31/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
L. Dwight Wooster, M.D.					1825 Howell Road Hagerstown, MD. 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		Aug. 2, 1980		Rose Hill Cemetery		Hagerstown, Md.			
24 FUNERAL DIRECTOR NAME ADDRESS Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					AUG 4 1980		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a certificate of medical investigation must be filed with this certificate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8019115	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Percy J. RIDENOUR, SR.					2a. DATE OF DEATH MONTH DAY YEAR July 14, 1980			2b. HOUR AM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR August 1, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrical eng.		12b. KIND OF BUSINESS OR INDUSTRY mfg. co.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William C. Ridenour					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Gossard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO 162-05-5098		17 INFORMANT ADDRESS Percy J. Ridenour, Hagerstown, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic heart disease &amp; right hemiparesis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>2 day</i> <i>year</i>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/20/69</i> 19 <i>69</i> to <i>7/14/80</i> 19 <i>80</i> that (I) (we) last saw the deceased alive on <i>7/14/80</i> 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE <i>Richard E. Edwards M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 17, 1980		23c. NAME OF CEMETERY OR CREMATORY Norland Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Chambersburg, Pennsylvania			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>				

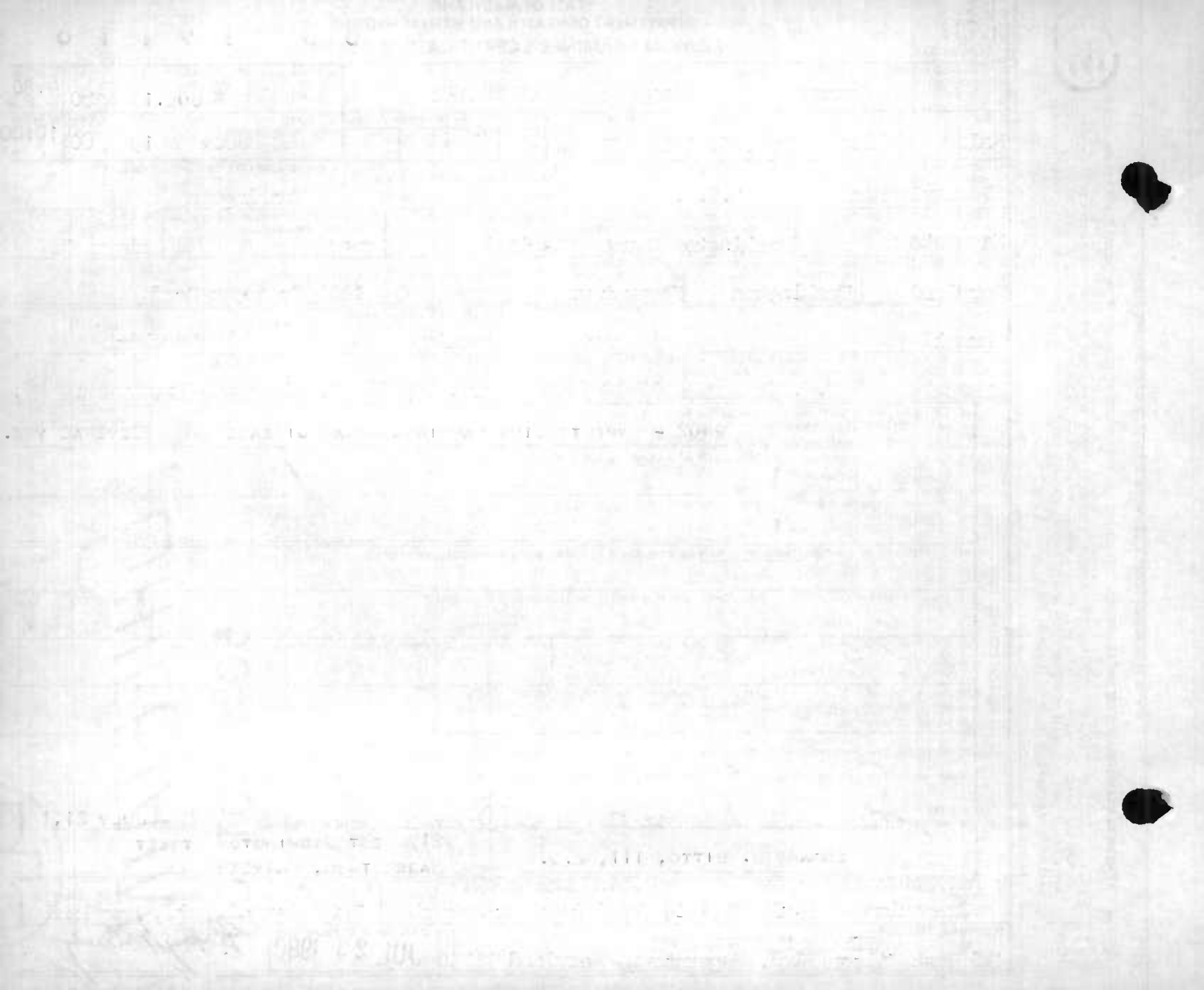


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 19116									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harry Ray RINEHART</b>									
2a. DATE OF DEATH		KNOWN <input type="checkbox"/> ESTI- MATED <input checked="" type="checkbox"/>		MONTH DAY YEAR <b>JUL. 19 19 80</b>		2b. HOUR <b>4:30 P M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 6, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62 YRS.</b>		IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>aircraft</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1222 Crescent Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arnold Rinehart</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Douthitt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>W.W. II 217-10-5090</b>		17. INFORMANT ADDRESS <b>Mrs. Phyllis L. Rinehart, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#402 - HYPERTENSIVE CARDIOVASCULAR DISEASE</b> 4029 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YRS.</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>JULY 21, 1980</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>July 22, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>			
415 East Wilson Blvd., Hagerstown, Maryland 21740									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1 - STATE  
REGISTRAR

CERTIFICATE OF DEATH

1 DECEASED NAME (TYPE OR PRINT) <b>EDITH ANN Ripple</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7/26/80</b>			2b. HOUR <b>10:50 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan, 17, 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		6 # UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>				
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frederick</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Butts</b>			13e. STREET ADDRESS <b>37 E. Potomac St.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT <b>Patricia Palmer</b>				ADDRESS <b>Item # 13X Above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO PULM ARREST</b> 492- DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>emphysema</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF INJURY <b>7/22/80</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>7/22/80</b> to <b>7/26/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>D. Wooster</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WOOSTER</b>			22e. ADDRESS <b>1825 HOWELL RD HAGERSTOWN MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 29, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport Washington MD</b>			
24 FUNERAL DIRECTOR NAME <b>Osborne Funeral Home P.O. Box 348 Wmspt., MD</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



Edith B. G. Ripple

11/2/30 10:00

088 200



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #16b Film G547 9/25/80 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 9 1 1 8

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ROELKE Charles Robert ROELKE, SR.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>July 3, 1980</b>			2b HOUR AM <b>M</b>			
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 29, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>			
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>post office</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>11 Marbern Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John R. Roelke</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vernie V. Karn</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>215-44-7313</b>			17 INFORMANT ADDRESS <b>Alice M. Roelke, Hagerstown, Maryland</b>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>4140</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
DUE TO, OR AS A CONSEQUENCE OF (b). <b>Arteriosclerotic Heart Disease</b>		17 years?	
DUE TO, OR AS A CONSEQUENCE OF (c).			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22 I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22a SIGNATURE <b>John H. Hornbaker (red)</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>7-3-80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. Hornbaker</b>			22e ADDRESS <b>645 E. First St., Hagerstown, Md. 21740</b>		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>July 7, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
--	--	---------------------------------	--	--	--	---	--

24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>			25a DATE REC'D. BY REGISTRAR <b>JUL 7 1980</b>			25b REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>		
415 E. Wilson Blvd., Hagerstown, Md. 21740								





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ruth  
RuthG.  
G.Sanders  
Sanders2a. DATE OF DEATH MONTH DAY YEAR  
July 31 19802b. HOUR  
2<sup>20</sup> A.M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
Sept. 17 19026. AGE (IN YEARS LAST BIRTHDAY)  
77 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Penna.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Washington Co.

MD.

10. CITY OR TOWN OF DEATH

Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Washington Co. Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Manager

12b. KIND OF BUSINESS OR INDUSTRY

School cafeteria

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.

13b. COUNTY

Washington

13c. CITY OR TOWN

Highfield

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Box 16

14. FATHER'S NAME

FIRST

John

MIDDLE

LAST

Riley

15. MOTHER'S MAIDEN NAME

FIRST

Mary

MIDDLE

M.

LAST

Steinberger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

218-01-3641A

17. INFORMANT

ADDRESS

Box 70

Harold L. Sanders Sr. Highfield, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1952

IMMEDIATE CAUSE (a) Abdominal carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 mo.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from May 19 80 to July 31 19 80, that (I) (we) lost saw the deceased alive on July 30 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Charles C. Spencer, M.D.

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

7-31-80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

138 E. Antietam St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/2/1980

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

23d. LOCATION

CITY OR TOWN  
FairfieldCOUNTY  
AdamsSTATE  
Penna.

24. FUNERAL DIRECTOR

NAME

David G. Gove

ADDRESS

50 S. Broad St.  
Waynesboro, Pa.

25a. DATE REC'D. BY REGISTRAR

AUG 7 1980

25b. REGISTRAR'S SIGNATURE

[Signature]

8 0 1 9 4 1 9

Senders

to

Address

Aug. 17 1903

Mr.

James

Washington Co.

x

Washington Co.

James

Good  
case

Manager

Washington Co.

Washington

Box 15

x

Washington

Washington

Mr.

Washington

Mr.

Mr.

Elmer

John

Box 10

218-21-311A James J. Sanders St. Washington, D.C.

As

Mr. E. Anderson St. Washington, D.C.

Charles E. Stewart, D.D.

Mr. J. J. Conner, Washington, D.C.

Large

Aug 2 1903

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert Lee SAUM			2a. DATE OF DEATH MONTH DAY YEAR July 13, 1980		2b. HOUR M
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR April 27, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY paper company	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Harry L. Saum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Favorite		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army	214-09-9078	17 INFORMANT ADDRESS Evelyn K. Saum, Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Black Cema with Uremia</u> 1889 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-13-80</u> to <u>7-13-80</u> , that (I) (we) last saw the deceased alive on <u>7-13-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. J. L. Saum</u>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-14-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (IF RECYCLED) burial	23b. DATE July 16, 1980	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR JUL 17 1980	25b. REGISTRAR'S SIGNATURE <u>Barry McCreedy</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR		8 0 1 9 1 2 1				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Evva Maude SCHROYER			2a DATE OF DEATH MONTH DAY YEAR July 24, 1980			2b HOUR 12:50 PM			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR February 14, 189		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Ravenwood Lutheran Home	
14 FATHER'S NAME FIRST MIDDLE LAST Mahlon Rice				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Malissa Grove					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. 216-07-8485		17 INFORMANT ADDRESS Mrs. Norma Nichols, 1008 Linwood Road			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: CA of Kidney									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (thX hospital) attended the deceased from <u>June 16</u> , 19 <u>70</u> , to <u>July 24</u> , 19 <u>80</u> , that (I) (Xe) lost saw the deceased alive on <u>July 24</u> , 19 <u>80</u> , and that in (my) (Xy) opinion death occurred on the date and hour and from the causes stated above. (I) (Xe) (Xy) view the body after death.									
22b SIGNATURE <i>Howard N. Weeks</i>				DEGREE M.D.P.A. ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED July 25, 1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.P.A.				22e ADDRESS 580 NOrthern Ave. Hagers. MD 21740					
23a BURIAL, CREMATION, REMOVAL burial		23b DATE July 28, 1980		23c NAME OF CEMETERY OR CREMATORY Myersville U.M. Church Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Myersville, Fred., Md.			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25a DATE REC'D. BY REGISTRAR AUG ' 1980		25b REGISTRAR'S SIGNATURE <i>Robert H. Hager</i>			
415 E. Wilson Blvd., Hagerstown, Md. 21740									

1 2 3 4 5 6 7 8

*Handwritten signature*





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 9 1 2 2

1 DECEASED NAME (TYPE OR PRINT) <i>Bertha May SMALL</i>			2a DATE OF DEATH MONTH DAY YEAR <i>July 10 1980</i>			2b HOUR M <i>10</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 13 1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i> MD				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Realtor</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>					13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hancock</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry SENSEL</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen Weaver</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mrs. Wilda Smith 215 Baptist Rd. Hancock Md</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Left Hemispheric Cerebro-vascular Accident</i>										
19a. DATE OF OPERATION <i>n.a.</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <i>(signature)</i> attended the deceased from <i>July 6, 1980</i> to <i>July 10, 1980</i> , that (I) <i>lost</i> saw the deceased alive on <i>July 10, 1980</i> , and that in (my) <i>lost</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>lost</i> (did not view the body after death).										
22b. SIGNATURE <i>Charles C. Spencer</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>07/15/80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles C. Spencer, M. D.</i>				22e. ADDRESS <i>1198 Kenly Avenue Hagerstown, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7-14-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Tonoloway Baptist</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Warfordsburg Fulton Penna.</i>				
24. FUNERAL DIRECTOR NAME <i>Richard J. Grove</i>				ADDRESS <i>Hancock MD</i>		25. DATE REG'D BY REGISTRAR <i>JUL 22 1980</i>		25. REGISTRAR'S SIGNATURE <i>(signature)</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 9 1 2 3 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Charles Ellsworth SMITH				2a. DATE OF DEATH MONTH DAY YEAR July 9, 1980			
3 SEX Male				2b. HOUR 1930 M			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR August 30, 1942		6 AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chestnut Grove, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Melvin Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Holmes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-18-8408		17 INFORMANT ADDRESS Mrs. Audrey V. Smith, 9 E. Lincoln Ave. Hagerstown, Md. 21740	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca of employee</u> 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> (c) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from April 57 to July 9 1980, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on July 9 1980, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <u>Howard N. Weeks</u> DEGREE M.D.P.A. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED July 11, 1980							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.P.A. 22e. ADDRESS 580 Northern Ave. Hagers. MD 21740							
23a. BURIAL, CREMATION, REMOVAL SPECIFIC Burial 23b. DATE 7-12-80 23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery 23d. LOCATION Samples Manor, Wash. Co., Md.							
24 FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Maryland 21713 25a. DATE REC'D. BY REGISTRAR JUL 15 1980 25b. REGISTRAR'S SIGNATURE <u>Robert M. Kelly</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Smith, Mary Jane

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

19124

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY JANE SMITH			2a. DATE OF DEATH MONTH DAY YEAR 7 24 80			2b. HOUR 10 <sup>50</sup> A.M.			
3 SEX F		4 RACE Cau		5 DATE OF BIRTH MONTH DAY YEAR October 29, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) assembler		12b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 103	
14. FATHER'S NAME FIRST MIDDLE LAST Karl T. Kubert					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Ramsey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-20-1742		17 INFORMANT ADDRESS Lewis W. Smith, Sr., Keedysville, Md. 21756					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 1 1/2 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>April 20</u> , 19 <u>80</u> , to <u>July 29</u> , 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>7/23</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/29/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave., Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 9 1 2 5				
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P
Truman		Paul		Smith				Jul 9 1980					2008	M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS				
male		white		Oct 16 1909		70		MONTHS		DAYS		HOURS		MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA				Washington County								MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Hagerstown		Washington County Hospital		Self Employed		Truck Driver								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		100 Lincoln St.						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST				
William		W.		Smith		Etta		May		Kline				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		---		214-30-1957		Peggy R. Smith		1004 Lincoln Street		Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Carcinoma of the Esophagus										3 months				
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)				
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
Carcinoma of the Cecum														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
Jun 9 1980		Carcinoma of the cecum		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
		P.M. 19		none										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK														
22a. I certify that (I) (this hospital) attended the deceased from Jun 4 1980 to July 9 1980, that (I) (we) last saw the deceased alive on July 9 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. JMA														
22b. SIGNATURE		DEGREE		22c. DATE SIGNED										
Francisco G. Japzon,		M.D.		Jul 10 1980										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
Francisco G. Japzon, M.D.		645 E. First St. Hagerstown, Md. 21740												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE		
Burial		9-11-80		Chewsville Cemetery		Chewsville, Washington, Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF DEATH		25b. REGISTRAR'S SIGNATURE								
A.K. Coffman Funeral Home, Inc.,		Hagerstown, Md.		Jul 11 1980		[Signature]								

BP

A. J. Colman Funeral Home, Inc., Everett, Wash.

Funeral Home, Everett, Wash.

Funeral Home, Everett, Wash.

Funeral Home, Everett, Wash.

Funeral Home, Everett, Wash.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div style="display: flex; justify-content: space-between;"> <div>1 - FOR STATE REGISTRAR</div> <div>8 0 1 9 1 2 6</div> </div>									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
<div style="display: flex; justify-content: space-between;"> <div>FIRST <b>GUY</b></div> <div>MIDDLE <b>J.</b></div> <div>LAST <b>SPENCER</b></div> </div>					<div style="display: flex; justify-content: space-between;"> <div>MONTH <b>JULY</b></div> <div>DAY <b>17</b></div> <div>YEAR <b>1980</b></div> </div>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
				<div style="display: flex; justify-content: space-between;"> <div>MONTH <b>JUNE</b></div> <div>DAY <b>6</b></div> <div>YEAR <b>1912</b></div> </div>		<div style="display: flex; justify-content: space-between;"> <div><b>68</b></div> <div>YRS</div> </div>		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
<b>MD.</b>		<b>U.S.A.</b>				<b>WASHINGTON CO. MD.</b>			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>SMITHSBURG</b>		<b>EDGEMONT RD. BOX 137 R.D.#3 SMITHSBURG</b>				<b>STATIONARY ENGINEER</b>		<b>TOOL CO.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
<b>MD.</b>		<b>WASHINGTON</b>		<b>SMITHSBURG</b>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>BOX 137 R.D.#3 EDGEMONT RD. SMITHSBURG</b>	
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
<div style="display: flex; justify-content: space-between;"> <div>FIRST <b>FRANK</b></div> <div>MIDDLE <b>E.</b></div> <div>LAST <b>SPENCER</b></div> </div>					<div style="display: flex; justify-content: space-between;"> <div>FIRST <b>IDA</b></div> <div>MIDDLE <b>L.</b></div> <div>LAST <b>SCHILT</b></div> </div>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT		
<b>NO</b>					<b>220-10-5688</b>		<b>ROBERT D. SNIVELY</b>		
					ADDRESS <b>217 ROESSNER AVE. HAGERSTOWN, MD.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b>									
5303 DUE TO, OR AS A CONSEQUENCE OF									
<div style="display: flex; justify-content: space-between;"> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</div> <div>(b) <b>Esophageal Structure</b></div> </div>									
<div style="display: flex; justify-content: space-between;"> <div></div> <div>(c) <b>Anemia and weight loss 2° to 6°</b></div> </div>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-9</b> , 19 <b>80</b> , to <b>7-16</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7-16</b> , 19 <b>80</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <b>Eric M. Wagshal</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-18-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eric M. Wagshal, M.D.</b>						22e. ADDRESS <b>1825 Howell Road Hagerstown, MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/19/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARBAUGH'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WAYNESBORO FRANKLIN PENNA.</b>		
24 FUNERAL DIRECTOR NAME <b>David M. Love</b>			ADDRESS <b>50 S. BROAD ST. WAYNESBORO, PENNA.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert D. Snively</b>	

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WALTON, R. 1992. *WALTON*

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100-443886-100

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

D. THOMPSON

DATE: 11/11/1964  
BY: J. A. KELLEY

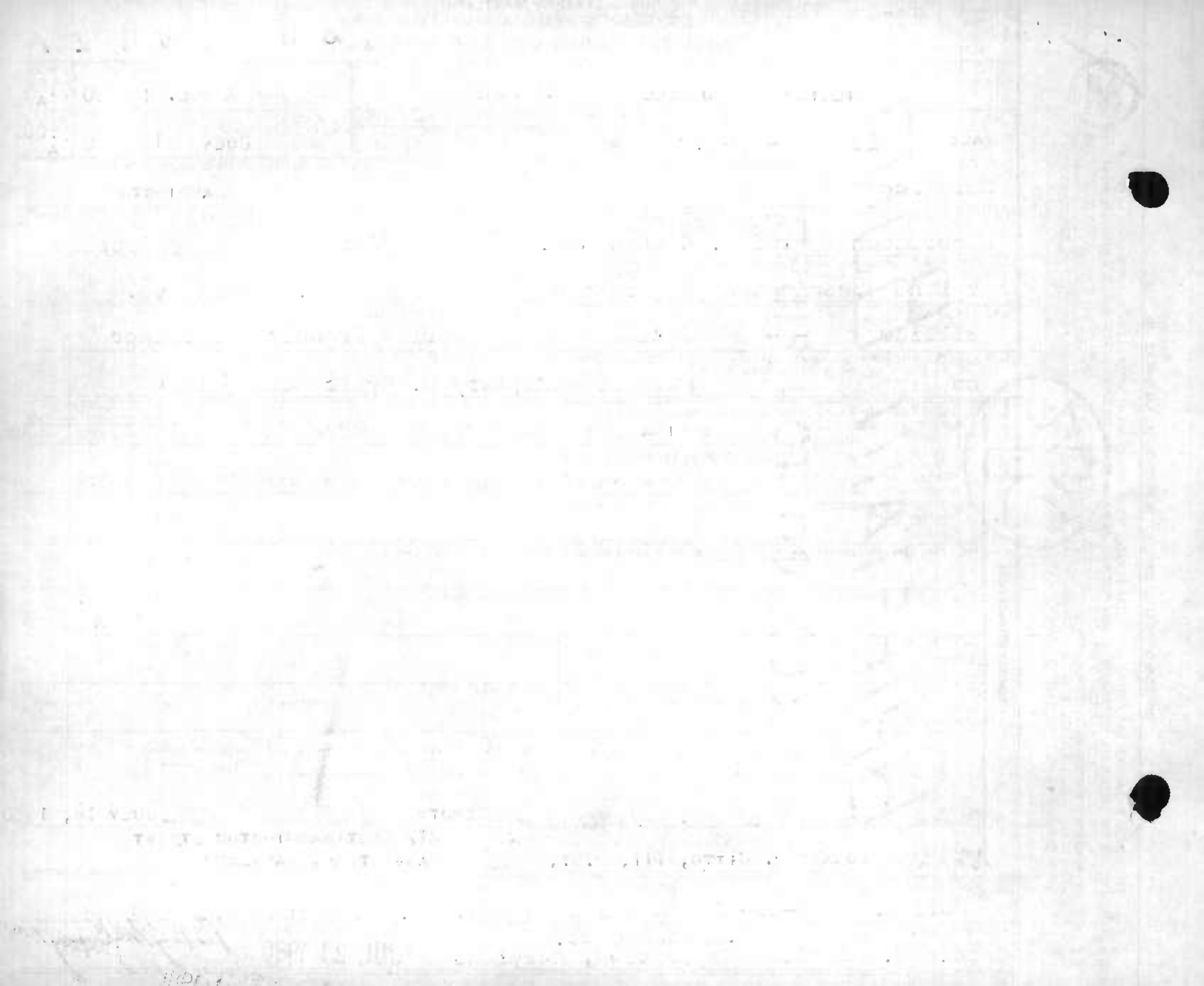
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ROBERT D. SWEET

SSO-IO-053

FOR #18a-22a Film G-47 9725780										STATE OF MARYLAND																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
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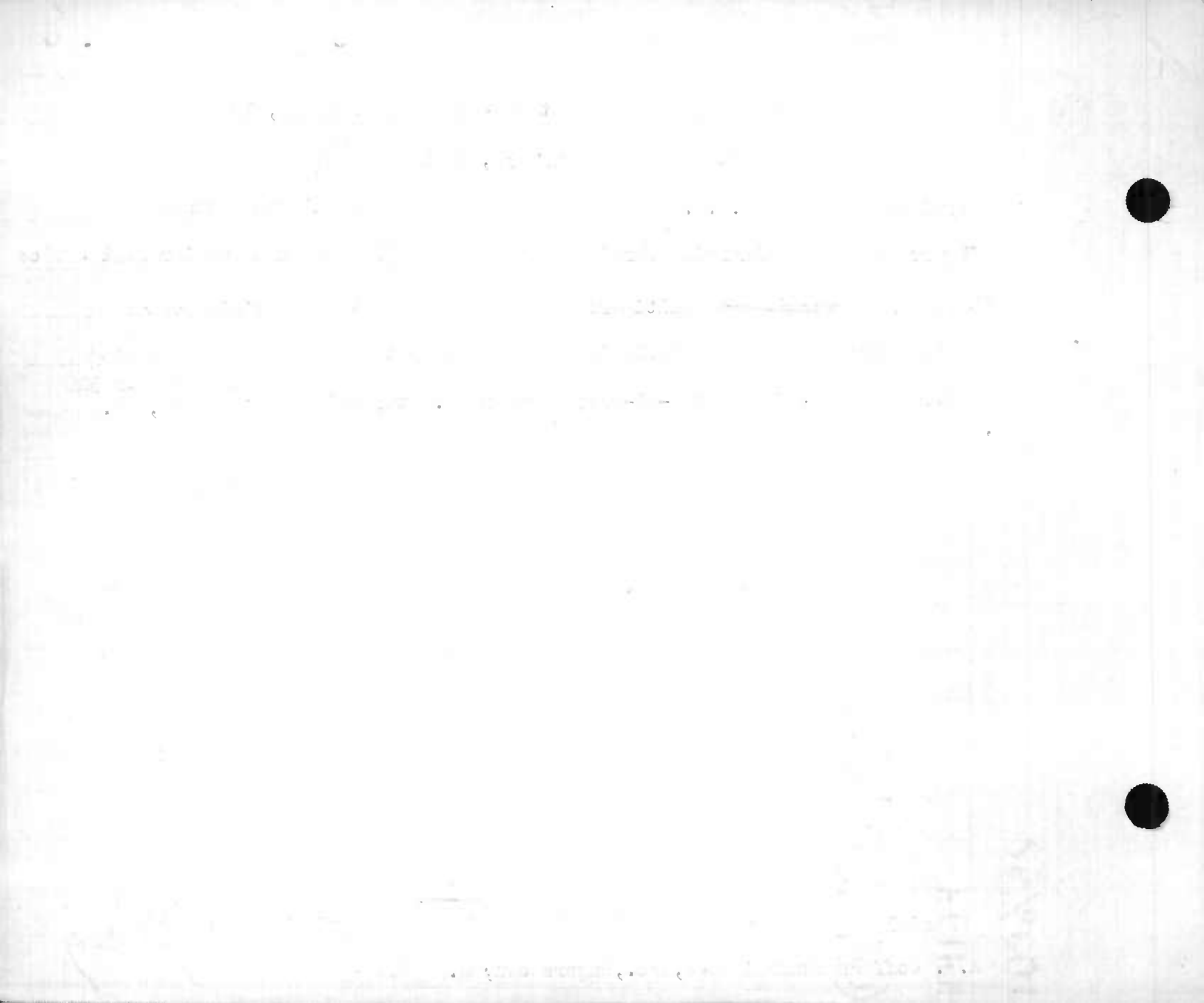
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 1 2 8			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Theodore (NMN) Staeblein				2a DATE OF DEATH July 18, 1980		2b HOUR 6:30 P.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH May 31, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Parcel Post Carrier		12b KIND OF BUSINESS OR INDUSTRY Post Office	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Theodore		15 MOTHER'S MAIDEN NAME Margaret Ranning		13e STREET ADDRESS 2860 Mayfield Avenue			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW I 218-42-8379		17 INFORMANT Edward T. Staeblein		ADDRESS Route # 2 Box 320 Smithsburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Brain syndrome</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>July 18, 1980</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>J. D. Wilson</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>7/19/80</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. D. WILSON</u>		22e ADDRESS <u>580 HAGERSTOWN, MARYLAND</u> <u>Northern Ave.</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>7-21-80</u>		23c NAME OF CEMETERY OR CREMATORY <u>Monahan Memorial</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore</u>	
24 FUNERAL DIRECTOR NAME <u>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</u>				25a DATE REC'D. BY REGISTRAR <u>JUL 25 1980</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



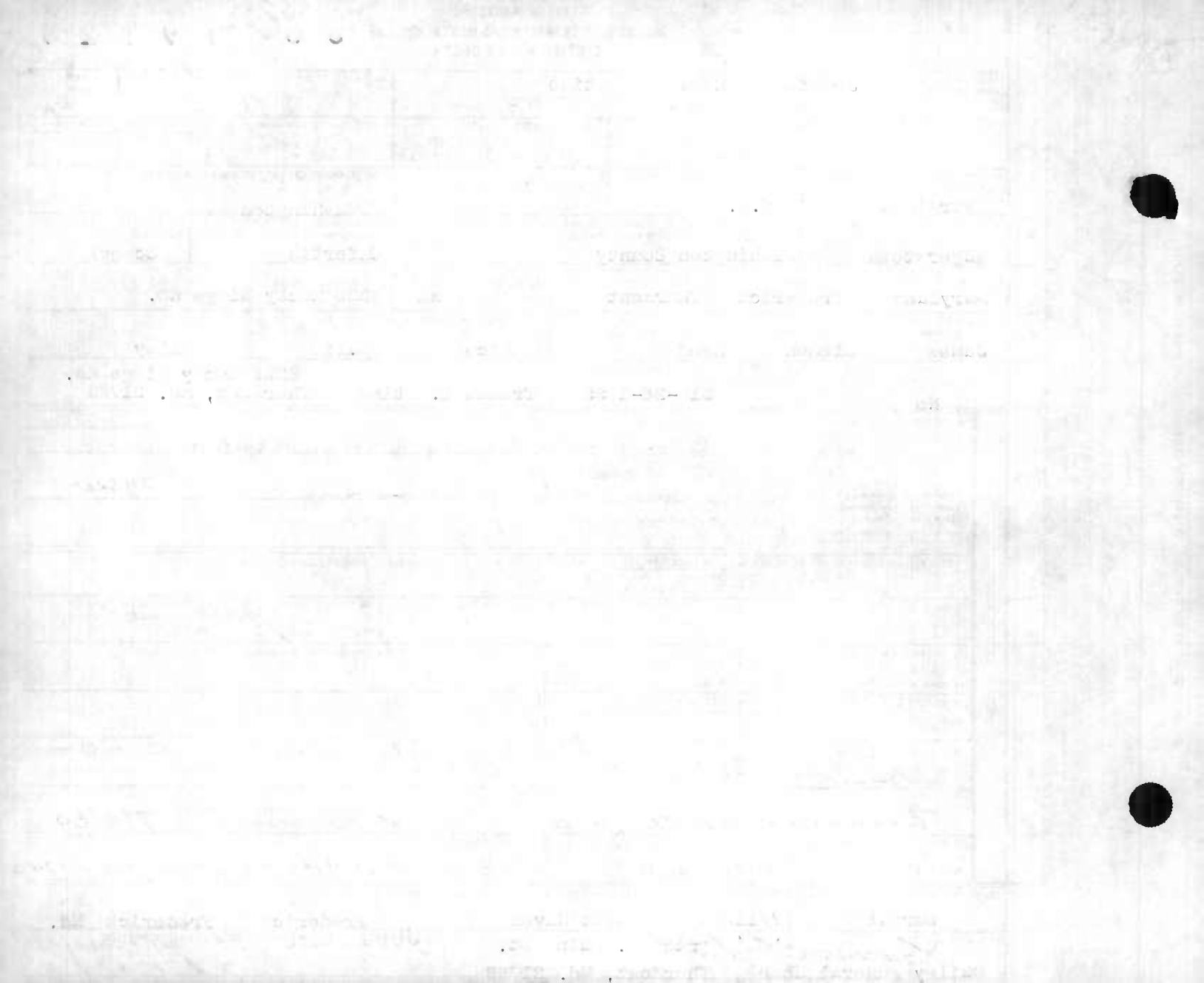
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 1 9 1 2 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JESSIE REBA STINE		2a. DATE OF DEATH MONTH DAY YEAR 7 8 80		2b. HOUR 10:45 AM	
3. SEX F	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR 5 28 1915		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) Washington County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Thurmont	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Solomon Reed		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Dalie Alley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-24-1355		17. INFORMANT ADDRESS 8226 Rocky Ridge Rd. Thurmont, Md. 21788	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of ovary with widespread</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>abdominal carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1830</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pancytopenia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>77</u> , to <u>July 8</u> , 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>7/7</u> , 19 <u>80</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) did not view the body after death.					
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.		22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/11/80	23c. NAME OF CEMETERY OR CREMATORY Rest Haven		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.	
24. FUNERAL DIRECTOR NAME <u>Dailey Funeral Home</u>		ADDRESS 615 E. Main St. Thurmont, Md. 21788		25a. DATE REC'D BY REGISTRAR JUL 11 1980 25b. REGISTRAR'S SIGNATURE	

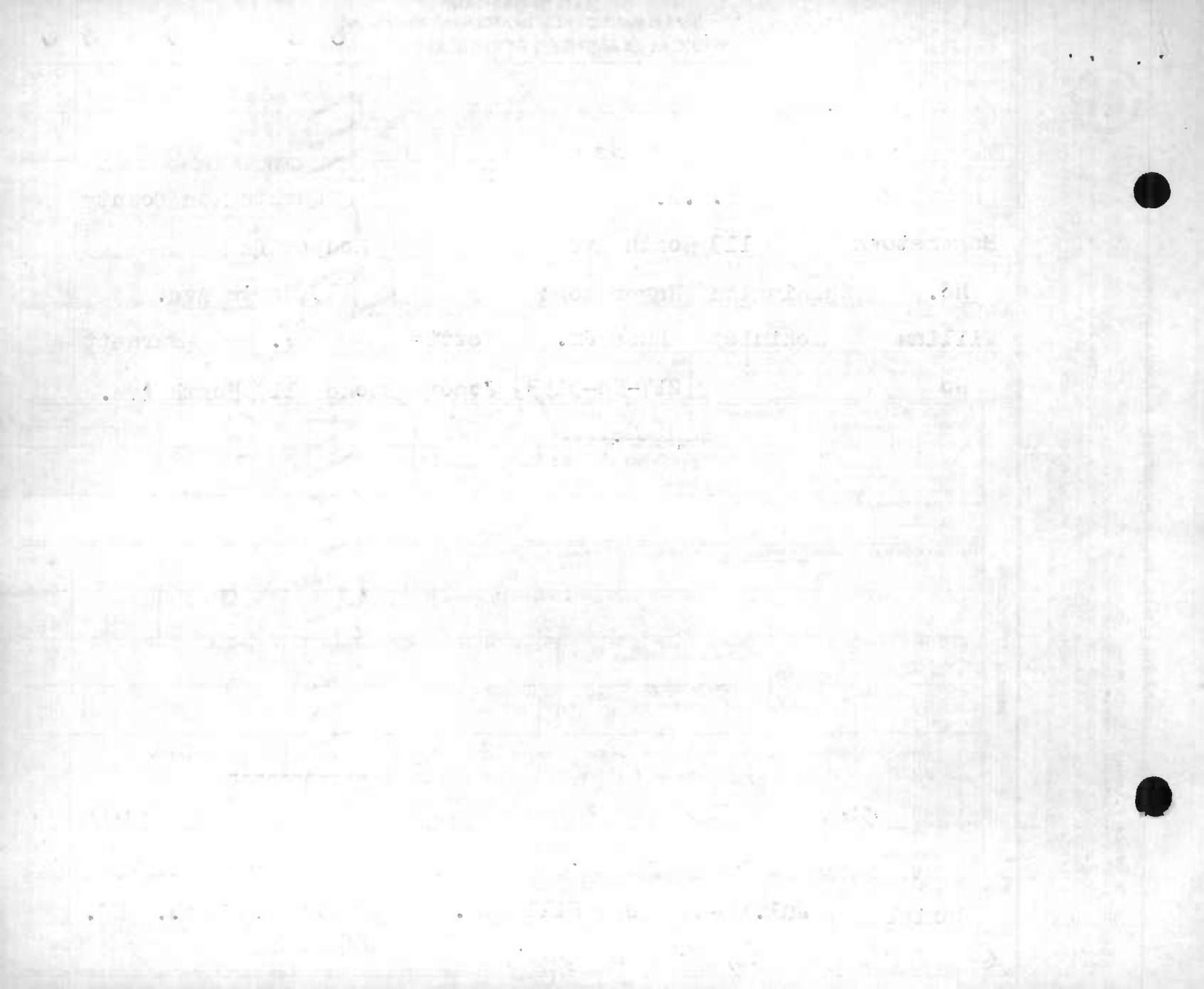
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19130	
1. DECEASED NAME (TYPE OR PRINT) <b>ToAnn NMN Stone</b>										2a. DATE KNOWN OF ESTI. DEATH MATED <b>X</b> <b>July 11, 80</b>	
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>23</b> YEAR <b>47</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>33</b> YRS	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>July 11 1980</b>		2b. HOUR <b>8:55</b> AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>119 North Ave</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>119 North Ave.</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Mckinley</b> LAST <b>Russ Jr.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Nettie</b> MIDDLE <b>V.</b> LAST <b>Burnett</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-58-3153</b>		17. INFORMANT <b>Joseph Stone</b>		ADDRESS <b>119 North Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>undetermined</b> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>caused hypoxia</b> 410 (c) <b>Thrombosis of artery to atrioventricular node</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>Harold R. Tritch</b>				TITLE (SPECIFY) <b>Asst.</b>				MEDICAL EXAMINER DATE SIGNED <b>7/11/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Harold R. Tritch, Jr., M.D.</b>				ADDRESS <b>138 E. Antietam St. Hagerstown, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jul. 16-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis L. Harris</b>				ADDRESS <b>Smithsburg, Md</b>				25a. DATE RECEIVED BY REGISTRAR <b>JUL 15 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony [Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	9	1	3	1
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Paul Charles STONER										2a. DATE OF DEATH 7-23-80				2b. HOUR M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 7-9-16			6. AGE (IN YEARS LAST BIRTHDAY) 64			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.							
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grounds Foreman			12b. KIND OF BUSINESS OR INDUSTRY College			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA 13b. COUNTY Adams 13c. CITY OR TOWN Fairfield										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD#2				
14. FATHER'S NAME Charles Stoner					15. MOTHER'S MAIDEN NAME Mary B. Cook											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 160-16-6814					17. INFORMANT Ock Hee Stoner					ADDRESS RD#2 Fairfield PA 17320						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 RESPIRATORY ARREST (b) BLOOD TOXIC CARCINOMA (c) LARVACEAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7/23/80 to 7/23/80, that (I) (we) last saw the deceased alive on 7/23/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE C.D. Wooster MD										DEGREE		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WOOSTER										22e. ADDRESS 1825 HOWE RD APT. 110						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 7-26-80		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Gettysburg Adams PA					
24. FUNERAL DIRECTOR NAME Lawrence E. Wilson, ADDRESS Fairfield, Pa.										25a. DATE REC'D. BY REGISTRAR AUG 5 1980		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 1 9 1 3 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vera Gladys STOUFFER				2a. DATE OF DEATH MONTH DAY YEAR July 11, 1980		2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Broadfording Road	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Griffith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-09-5748		17. INFORMANT ADDRESS Mrs. William Snook, Hagerstown, Maryland			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the pancreas</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 6 mos. "	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> , 19 <u>80</u> , to <u>7/11</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7/11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas W. Craig</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/12/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas W. Craig, M.D.				22e. ADDRESS 239 N. POTOMAC Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 14, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR JUL 17 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			

General order  
Huffman Administration  
Department of the Interior

Thomson O. Long  
MD  
2nd Assistant  
Thomson O. Long

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 1 Per Ph. call with F.H. 7/16/80				STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 1 3 3			
FOR 1- STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Martha Elizabeth VIOLET				Ellen Elizabeth VIOLET				July 13, 1980				2:30P M			
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)				7a. UNDER 1 YEAR		7b. UNDER 24 HRS	
Female		White		August 26, 1987				92				MONTHS DAYS		HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH							
Locust Grove, Md.		U. S. A.						Washington				MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital				Housewife				Own Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. CITY OR TOWN				13c. STREET ADDRESS			
Maryland				Washington				Hagerstown				935 Corbett St.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Lawrence Poffenberger				Mary Smith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS											
NO		220-16-3244B		Mrs. Gladys L. Roche, 2350 Marsh Pike Hagerstown, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Anoxia</i>												MIN			
410 - DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i>												HRS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>atherosclerosis</i>												YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Angrene Both feet 48 hrs duration</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9 July 1980</i> to <i>13 July 1980</i> , that (I) (we) last saw the deceased alive on <i>10 July 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. D. Wilson</i>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>7/14/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
J. D. Wilson, M. D.				580 Northern Ave., Hagerstown, Md. 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				7-16-80		Locust Grove Cemetery				Locust Grove, Wash. Co., Md.					
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr. Boonsboro, Md. 21713								JUL 16 1980				<i>Jeffrey Kennedy</i>			

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Age 25, 1880

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TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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19134

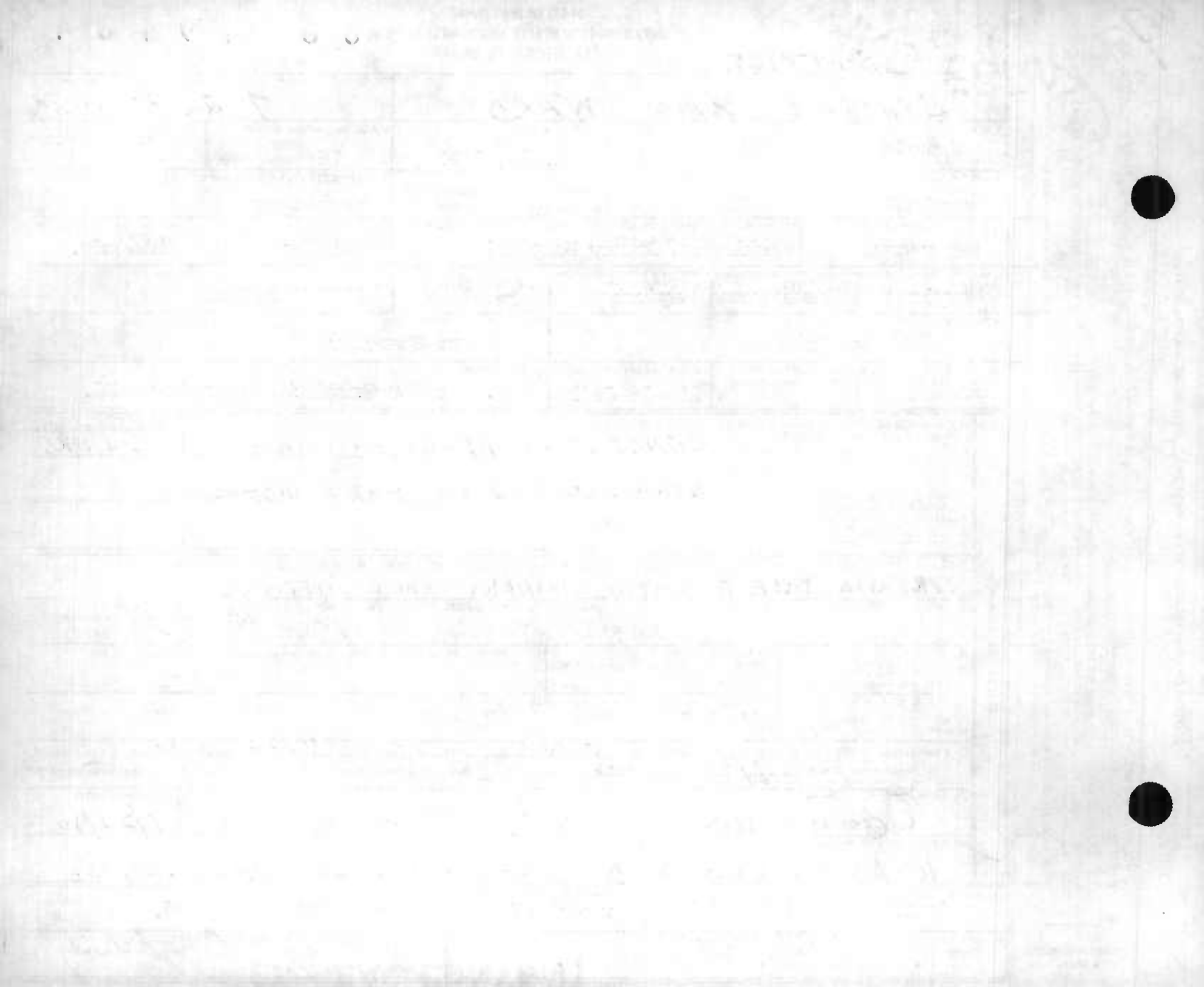
1. FOR  
STATE  
REGISTRAR

BEATRICE

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE NMN WARD</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>80</b>			2b. HOUR <b>5:55 A.M.</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>10</b> YEAR <b>1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>stitcher</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Roberts</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Laura</b> MIDDLE <b>Stansbury</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-14-6063</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Griffith, Hagerstown, Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>CONGESTIVE HEART FAILURE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>CIREMIA DUE TO SEVERE URINARY TRACT INFECTION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/23</b> , 19 <b>73</b> , to <b>7/22</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>7/21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. Amarillo</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/22/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. AMARILLO M.D.</b>				22e. ADDRESS <b>127 KING ST HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>July 24, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery</b>		23d. LOCATION CITY <b>Hagerstown</b> COUNTY <b>Washington</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Minnich Funeral Home</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy Griffith</b>	



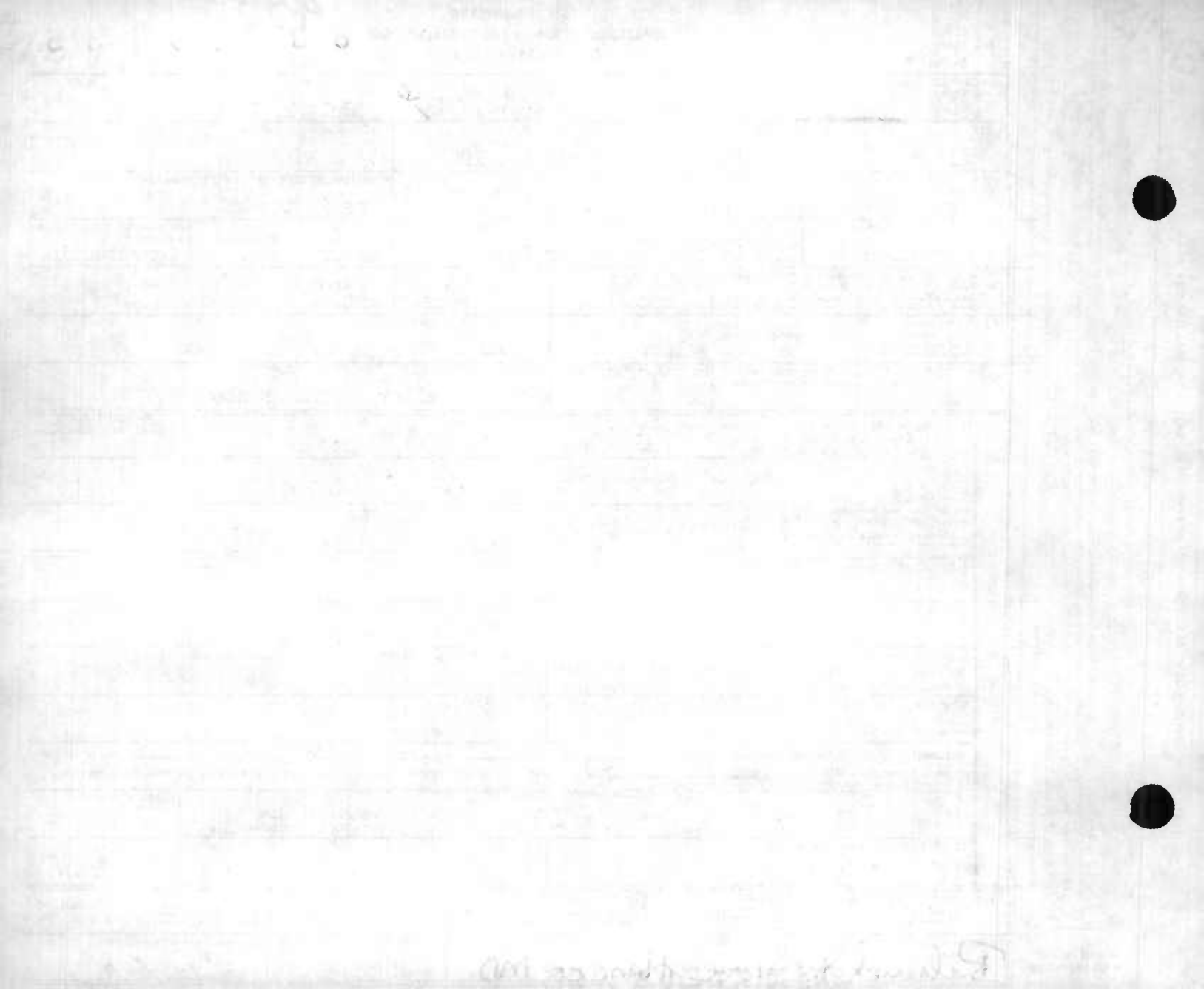
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8019135
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>WELLER LUTHER AUGUST</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 1, 1980</b>					2b. HOUR <b>M</b>
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 14, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN <b>MD.</b>
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hancock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #2</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Issac Weller</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Reed</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>220 09 9198</b>		17. INFORMANT ADDRESS <b>Mary E. Weller same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 TOXEMIA - ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF <b>LEFT FOOT GANGRENE</b> (b) <b>ASCLOS - DIABETES MELLITUS</b> (c) <b>ASCLOS - DIABETES MELLITUS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6.30</b> , 19 <b>80</b> , to <b>6.30</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>6.30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Otto Roza</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7.1.80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OTTO ROZA</b>					22e. ADDRESS <b>100 LONG MEADOW DR. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-3-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Orchard Ridge Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hancock Washington Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Richard J. Love Hancock MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard J. Love</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 9 1 3 6			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Isolde		Annita		WHETZEL		July 2, 1980		12:05A					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS			
Female		White		June 15, 1919		61		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Adelaide, Australia		U. S. A.				Washington		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		DOA Washington County Hospital		Nurse		Nursing							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		20 Wynnwood Dr.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Albrecht		Fehlberg		No		214-28-7267		Mr. Weldon F. Whetzel,		20 Wynnwood Dr.		Hagerstown, Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Chronic obstructive lung disease</i>										61			
496- DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Cor pulmonale													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <i>Oct 11</i> , 19 <i>68</i> , to <i>July 2</i> , 19 <i>80</i> , that (2) <input checked="" type="checkbox"/> we last saw the deceased alive on <i>May 29</i> , 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) <input checked="" type="checkbox"/> we did not view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Richard E. Smith, M.D.						7/3/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Richard E. Smith, MD		1708 Oak Hill Ave. Hagerstown, Md											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		7-5-80		Greenlawn Mem. Park		Williamsport, Wash. Co., Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John H. Bast, Jr.		Boonsboro, Md. 21713		JUL 8 1980		Richard E. Smith							



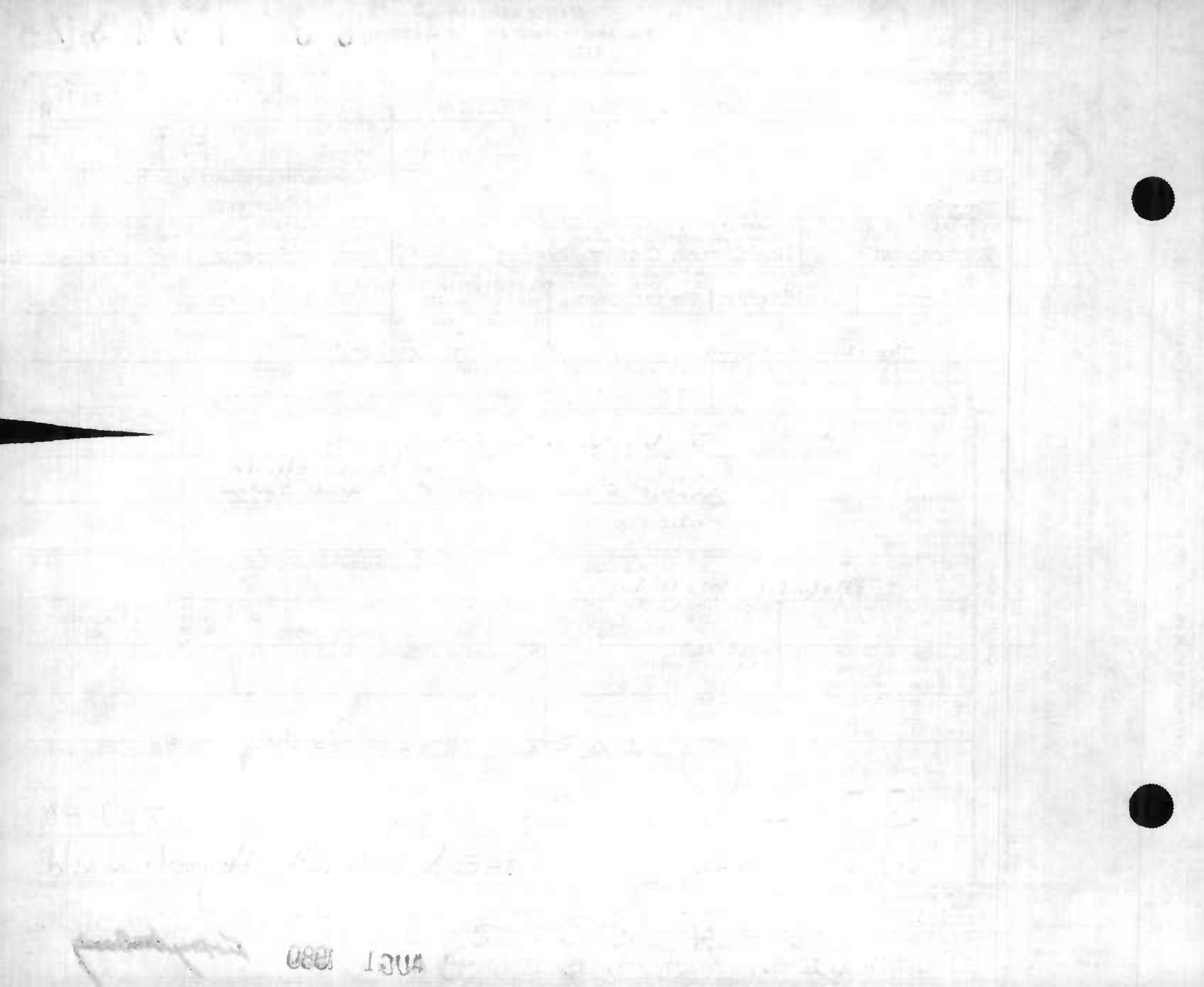
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 8:45 AM	
Charlotte Frances		WHITE						July 28, 1980			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR December 13, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mgr. cafeteria			12b. KIND OF BUSINESS OR INDUSTRY school element.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 5, Box 12			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Deibert						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rowland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7828D		17. INFORMANT ADDRESS Roger Thomas, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Intra-Vascular Embolization</u> <u>4/40</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial Fibrillation secondary to Anteroselective Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>16 Dec</u> , 19 <u>68</u> , to <u>28 July</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. N. Fender</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-29-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender				22e. ADDRESS 138 E Antietam St. Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE July 31, 1980		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR AUG 1 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
415 E. Wilson Blvd., Hagerstown, Md. 21740											

BP \_\_\_\_\_



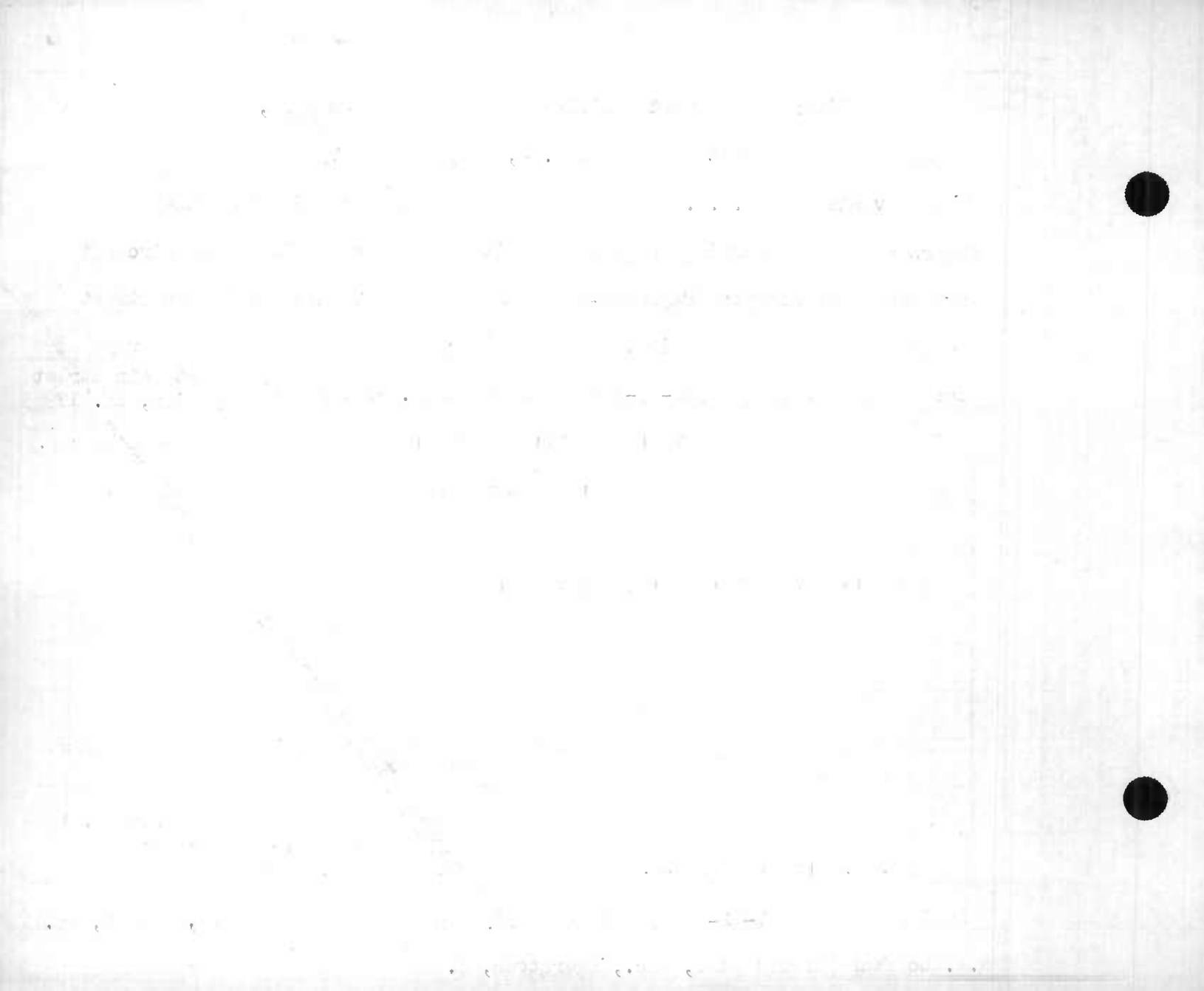


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 9 1 3 8
1. FOR STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <b>Oliver Roosevelt Wible</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1980</b>			2b. HOUR <b>4:45</b> A M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool &amp; Die Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7 East Washington Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wible</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Elvey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW II 560-05-4608</b>		17. INFORMANT ADDRESS <b>Elizabeth A. Bowman 1524 West Main Street Valley View, Pa. 17983</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF AND CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YRS.</b> <b>2 WEEKS</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PNEUMONIA; STAPH EPIDERMIDES BACTECEMIA</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <del>(HE)</del> <del>(SHE)</del> attended the deceased from <b>JUNE 28</b> , 19 <b>80</b> , to <b>JULY 19</b> , 19 <b>80</b> , that (I) <del>(HE)</del> <del>(SHE)</del> last saw the deceased alive on <b>JULY 18</b> , 19 <b>80</b> , and that in (my) <del>(my)</del> <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) did not view the body after death, so state.)										
22b. SIGNATURE <b>Edward W. Ditto, III, M.D.</b>					DEGREE		22c. DATE SIGNED <b>JULY 21, 1980</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>					22e. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-22-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethlehem Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>McConnellsburg, Fulton, Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>					25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 23 1980</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18c G546 8/20/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

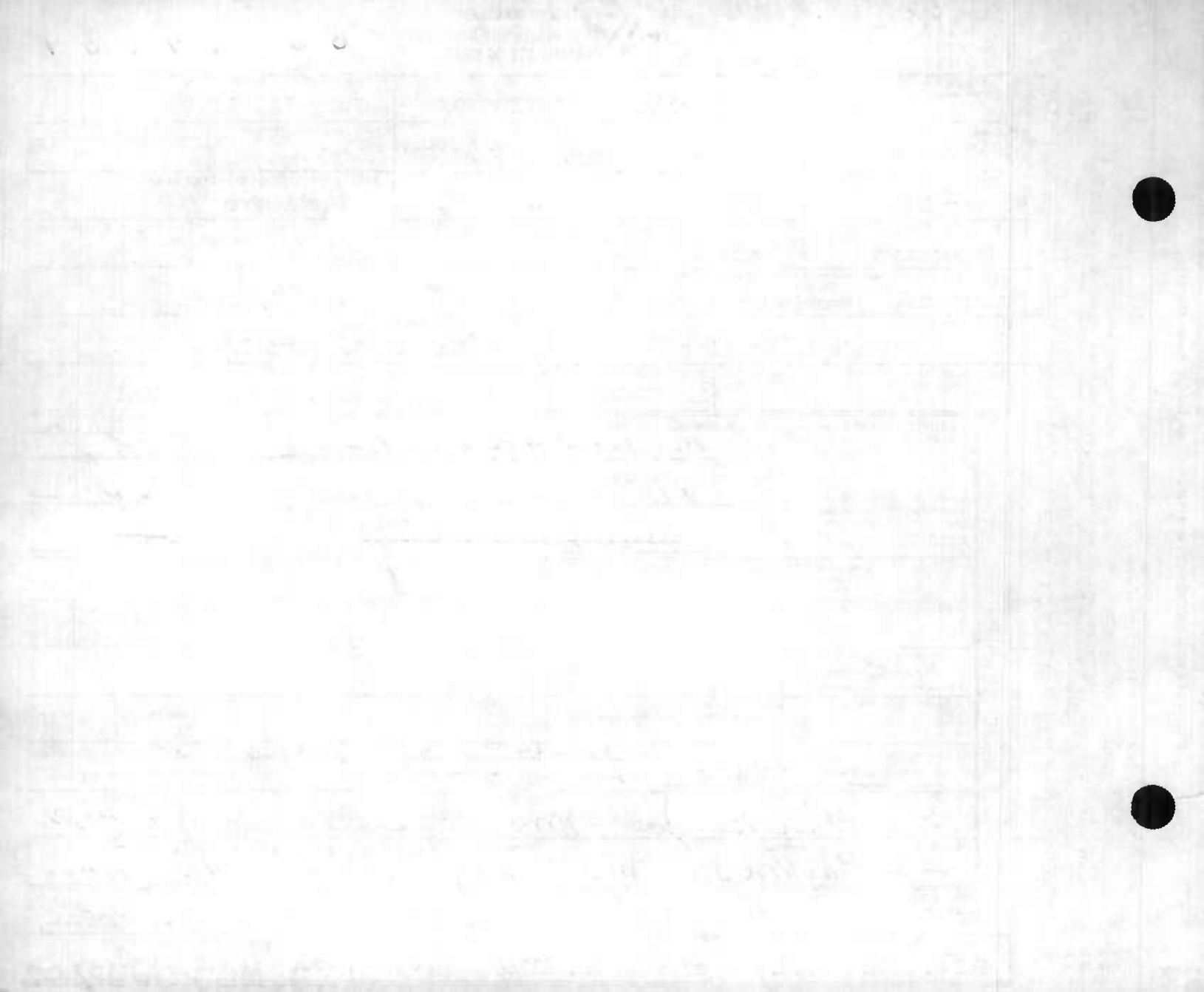
8019139

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Mary Estelle WORTHINGTON			2a DATE OF DEATH MONTH DAY YEAR July 16, 1980			2b HOUR M AM			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR October 31, 1886		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 4				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Route 4, Box 29	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph C. Hawkins					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie E. Duvall				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-76-3698		17 INFORMANT ADDRESS Nettie G. Burdette, Bowie, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerosis</u> (c) <u>Adventitious</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days Unk Unk	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 14</u> 19 <u>80</u> to <u>July 16</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>July 16</u> 19 <u>80</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. <u>Natural</u>									
22b SIGNATURE <u>L L Packer Jr</u> MD						DEGREE MD		22c DATE SIGNED 7/17/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) L L Packer Jr MD						22e ADDRESS 145 W. Washington St Hagerstown, Md 21740			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b DATE July 19, 1980		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a DATE REC'D. BY REGISTRAR JUL 23 1980		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 9 1 4 0			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
John Thomas ZIMMERMAN				July 3 1980			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		White		July 29 1935		44 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				WASHINGTON MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital		Maintenance		Trucking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt #1 Box 148	
Maryland Washington Sharpsburg							
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME			
John Will ZIMMERMAN				Fannie Mae Ebersole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No				216-30-3104		Audrey J Zimmerman Item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1 DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Several metastases</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Small cell carcinoma of lung</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u></u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 10</u> 19 <u>77</u> , to <u>July 3</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>July 2</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we last did not view the body after death.)							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Richard E. Smith, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Richard E. Smith, M.D.				1708 Oak Hill Ave, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		July 5, 1980		Sample Manor Cemetery		Sample Manor Washington Md.	
24 FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Major M. Osborne P.O. Box 348 Williamsport Md.				JUL 16 1980			

